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ABSTRACT

This document presents the curriculum for a pilot program for nontraditional students, held concurrently with a 13-week Medical Assistant Program, designed as a bridge into academic life. It notes that the program and its cognitive group counseling methodology are designed to strengthen the personal identity of students and to help them develop assertiveness skills and a sense of independence which will maximize their potential for academic success. The handbook briefly describes the program rationale; special features of the pilot program; program overview; pilot program goals; pilot program objectives; curricular units and objectives of the pilot program; evaluation procedures; and a pilot program curriculum outline, clinician's narrative, and researcher's validation of instructional intent and comments. It presents each of the program's 22 sessions in separate sections which list the session's objective, curriculum outline, primary sources of instruction, clinician's narrative, and researcher's validation of instructional intent and comments. References are included; relevant materials, inventories, and a program evaluation form are appended. (NB)

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A Handbook Supplemental to the Thesis Entitled:

The Effects of a Group Counseling Intervention on Self-Concept, Self-Esteem, Anxiety and Grade Point Average of Female, Nontraditional Students

By

Beverly Jean Grottkau

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Urban Education

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December 1985

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Bridging the Gap: A Pilot Program

For the Nontraditional Student

By

Beverly J. Grottkau, Ph.D.

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BRIDGING THE GAP: A PILOT PROGRAM FOR THE NONTRADITIONAL STUDENT

I. PROGRAM RATIONALE

There is a growing body of evidence which suggests that adult nontraditional students often enter college encountering a variety of psychological and situational conflicts. The intensity and brevity of the Medical Assistant Program, in concert with the myriad of skills which students are expected to acquire, tend to exacerbate the existing conflicts. This pilot study is intended as a bridge into academic life. The specific program of instruction, and its concomitant cognitive group counseling methodology, is designed to strengthen the personal identity of individual participants and to help students develop assertiveness skills, as well as a sense of independence, which will maximize their potential for academic success.

II. SPECIAL FEATURES OF THE PILOT PROGRAM

This special non-credit, non-graded program is held concurrently with the regularly scheduled 13-week Medical Assistant Program. Twenty-two, 60-minute sessions are conducted every week (on Mondays and Wednesdays unless otherwise noted) immediately following the Medical Assistant Program coursework. Attendance is mandatory. No fees are assessed students for their participation in the pilot program. Given the special features of the workshops, it is open only to students who are currently enrolled in Concordia College's Medical Assistant Program, a nontraditional course offering.

III. PROGRAM OVERVIEW

A. The theme of the workshop is: "Don't like the way it is? Change it!" "It" is the way one is (one's personality), the way in which one looks at oneself, and the way one feels about oneself. "It" is one's perceptions of one's life and what is real to the one who lives that life.

B. Throughout the workshop, the following questions are asked:

1. What are you like? What do you see when you look at yourself? (Self-concept)
2. How did you come to see yourself this way? (Self perceptions as a function of one's perceptions of others' perceptions)
3. How do you feel about what you see when you look at yourself? What do you like about yourself? What don't you like about yourself? (Self-esteem)
4. How did you come to feel the way you do about what you are like? (Self appraisals as reflected appraisals)
5. What do you think you would like to be like? What would you like more, or less, of? What would you like to change?

C. A major emphasis of the pilot program relates to what it means to be assertive (goal), the obstacles that get in the way when an individual attempts to be assertive (malady), and the techniques which can be used to become more assertive (means).

D. Embedded in the pilot program is the basic assumption that people want to control their own lives. They want to own their own lives and live more independently. The formula which is used to help students become more independent is the ACT formula:

A = Accepting reality, C = Choosing to be more independent, T = Taking action. The ACT formula is applied to each of three areas of independence: physical independence, social independence, and emotional independence. In each case, discussion revolves around the nature of the particular independence, as well as those dependencies which might get in the way. Discussion also includes suggestions for ways in which students might overcome their dependencies so that they can ultimately choose, and subsequently act, independently.

IV. PILOT PROGRAM GOALS

The overall goal of the pilot program is to:

A. Bring about changes in self-concept, self-esteem and anxiety.

B. Maximize each student's potential for academic success in the Medical Assistant Program.

V. PILOT PROGRAM OBJECTIVES

As a function of an instructional format designed for students enrolled in Concordia College's Medical Assistant Program, in concert with a group counseling intervention heavily grounded in a cognitive therapeutic approach, the experience will result in:

A. Positive changes in self-concept.

B. An increase in self-esteem.

C. A decrease in anxiety.

D. Increased levels of academic performance.

VI. CURRICULAR UNITS AND OBJECTIVES OF THE PILOT PROGRAM

The program content is based on the works which appear in the sections entitled "primary sources of instruction" following each curriculum outline. The program instructor has also called upon his own vast

reservoir of experience and knowledge to formulate the various components of the program, and it would be extremely difficult, if not impossible, to identify and acknowledge the originators of these primary sources of information. In addition, while the techniques espoused by Albert Ellis (Rational-Emotive Therapy) and William Glasser (Reality Therapy) are fundamental to the strategies utilized in the group counseling process, it is important to point out that they are used in combination with the unique approach of the clinical psychologist delivering the program and predicated on his past experience in counseling adult females, as well as his personal philosophy of the psychology of women.

A. SESSION ONE: INTRODUCTION

1. To acquaint group members with the workshop facilitator.
2. To introduce students to the purpose of the workshop.
3. To discuss the overall theme of the workshop.
4. To begin to build a climate of trust.

B. SESSION TWO: OF CHICKENS AND EAGLES

1. To introduce the concept of self-esteem.

C. SESSION THREE: OF CHICKENS AND EAGLES (Cont'd)

1. To continue the discussion of self-esteem.
2. To introduce self-concept principles.

D. SESSION FOUR: PIGEONS

1. To introduce the concept of manipulation.
2. To discuss each form of manipulative ploy, why it works so well, and what can be done to counteract the ploy.

E. SESSION FIVE: MANIPULATION AND ASSERTIVENESS

1. To discuss the inappropriate, indirect methods of dealing with the anger which results from feeling manipulated.
2. To introduce the concept of assertiveness.

F. SESSION SIX: TARGETING YOUR ASSERTIVENESS DIFFICULTIES

1. To introduce the concept of the "neurotic spiral."
2. To describe and discuss the signs associated with a descending "neurotic spiral."

G. SESSION SEVEN: TARGETING YOUR ASSERTIVENESS DIFFICULTIES (Cont'd)

1. To identify assertive problem types.

H. SESSION EIGHT: BASICS OF ASSERTIVENESS TO HELP YOU GET STARTED

1. To help students think more personally about themselves.

I. SESSION NINE: THE EFFECTS OF YOUR ASSERTIVENESS ON THOSE AROUND YOU

1. To promote an understanding of the effects that assertiveness may have on others.

J. SESSION TEN: THE EFFECTS OF BEING ASSERTIVE ON THE ASSERTIVE WOMAN

1. To promote an understanding of the factors that often get in the way of becoming assertive.

K. SESSION ELEVEN: ASSERTION ON THE JOB

1. To introduce students to unassertive personality job types.
2. To acquaint students with the first of a seven-point guide to achieving assertion on the job.

L. SESSION TWELVE: ASSERTION ON THE JOB (Cont'd); INTRODUCTION TO INDEPENDENCE

1. To complete the discussion of the seven-point guide to achieving assertion on the job.
2. To introduce the concept of independence.

M. SESSION THIRTEEN: INDEPENDENCE (Cont'd)

1. To introduce students to the first step of the ACT formula: Accepting reality.

N. SESSION FOURTEEN: INDEPENDENCE (Cont'd)

1. To continue the discussion of the first step of the ACT formula: Accepting reality.

O. SESSION FIFTEEN: INDEPENDENCE (Cont'd)

1. To continue the discussion of the first step of the ACT formula: Accepting reality.

P. SESSION SIXTEEN: INDEPENDENCE (Cont'd)

1. To conclude the discussion of the first step of the ACT formula: Accepting reality.
2. To introduce students to the second step of the ACT formula: Choosing to be independent.

Q. SESSION SEVENTEEN: INDEPENDENCE (Cont'd)

1. To conclude the discussion of the second step of the ACT formula: Choosing to be independent.
2. To introduce students to the third step of the ACT formula: Taking action.

R. SESSION EIGHTEEN: PHYSICAL INDEPENDENCE

1. To introduce students to the topic of physical independence.

S. SESSION NINETEEN: EMOTIONAL INDEPENDENCE

1. To introduce students to the topic of emotional independence.

T. SESSION TWENTY: EMOTIONAL INDEPENDENCE (Cont'd)

1. To conclude the discussion of emotional independence.

U. SESSION TWENTY-ONE: SOCIAL INDEPENDENCE

1. To introduce students to the topic of social independence.

V. SESSION TWENTY-TWO: YOU ARE THE MOST IMPORTANT PERSON IN THE WORLD

1. To discuss the implications of being the most important person in the world.

VII. EVALUATION PROCEDURE

A. In order to investigate the efficacy of the pilot program in effecting changes in self-concept, self-esteem, and anxiety, the following measurement instruments are to be used in pre- and posttest conditions:

1. Tennessee Self-Concept Scale.

2. Sixteen Personality Factor Questionnaire.

3. Eight State Questionnaire.

B. Academic performance is to be evaluated on the basis of the grade point averages achieved by students in the Medical Assistant Program.

C. The results of scores derived from the measurements are to be compared to scores obtained in pre- and posttest conditions for a similar group of Medical Assistant students receiving no experimental program.

VIII. PILOT PROGRAM CURRICULUM OUTLINE, CLINICIAN'S NARRATIVE, AND RESEARCHER'S VALIDATION OF INSTRUCTIONAL INTENT AND COMMENTS

The following section provides a detailed account of each of the twenty-two sessions of the workshop. A curriculum outline is provided together with the clinician's narrative which was prepared at the end of each session. In addition, this researcher has provided an in-depth analysis of the "hidden curriculum," and has examined other important features of the workshop germane to this account.

SESSION ONE: INTRODUCTION

A. Objective

1. To acquaint group members with the workshop facilitator.
2. To introduce students to the purpose of the workshop.
3. To discuss the overall theme of the workshop.
4. To begin to build a climate of trust.

B. Curriculum Outline

1. Course overview.
   a. Theme: "Don't like it the way it is? Change it!"
   b. Questions to be addressed during the workshop:
      (1) "What are you like?" "What do you see when you look at yourself?" (Self-concept)
      (2) "How did you come to see yourself in this way?" (Self-perception as a function of one's perceptions of others' perceptions)
      (3) "How do you feel about what you see when you look at yourself?" (Self-esteem)
      (4) "How did you come to feel the way you do about what you are like?" (Self-appraisals as reflected appraisals)
   c. The meaning of assertiveness.
   d. The meaning of independence.
   e. Goal, malady and means approach defined.
      (1) What does it mean to be assertive (independent)?
      (2) What are the obstacles that get in the way when an individual attempts to be assertive (independent)?

(3) What techniques can be utilized in order to become more assertive (independent)?

f. The ACT Formula.

g. A brief discussion of the course conclusion: "You are the most important person in the world."

C. Primary Sources of Instruction

1. Chenevert, M. (1983).

2. Emery, G. (1982).

3. Taubman, B. (1976).

D. Clinician's Narrative

My intention was to establish rapport with the students. I wanted to let them know that the main thing that the group was about was support. The need for support became evident, I explained, during the time I counseled several Medical Assistant students when I previously served as Clinical Consultant to the college. I wanted the students to know that I knew something about the pressures and anxieties elicited by the intensity and rigors of the program. I wanted them to look at the group as their opportunity to share and to care. I wanted them to perceive me as the one to whom they could turn who would understand. I believed it was important to give them the perception that I would be a facilitator to help them open up and disclose their concerns. I also wanted to give them the perception that the group experience could be a great deal of help to them during the ensuing weeks because it would afford them a meaningful and beneficial change-of-pace from their otherwise pressure-filled routine.

While presenting the program content, I kept the presentation low-keyed and conversational. I tried to give the students the perception of a caring, nurturing, experienced professional who has no link with the college, and therefore no connection with the Medical Assistant teaching staff. I wanted them to recognize, however, that I had the wherewithal to help them and help them help each other and themselves.

Although there were problems with the audio equipment which drew considerable attention to the tape recorder, I used the malfunction to share with the students my own feelings of frustration. Despite the audio problem, I feel that I was able to accomplish what I had intended. From the students' mannerisms (facial expressions) and verbal responses, I perceived that it was a good beginning.

E. Researcher's Validation of Instructional Intent and Comments

Due to equipment failure, it is virtually impossible to validate the instructor's intentionality for the first session of the pilot program. Given the clinician's commentary, however, it appears that students were responsive. In addition, the malfunction was instrumental in providing the clinician an opportunity to openly confront reality. In this regard, studies suggest that one of the best ways to convince other people that a certain behavior is worthwhile is to see it manifest itself in the helper's own behavior (Combs, Avila, & Purkey, 1978). Hence, the clinician communicated genuineness and spontaneous self-disclosing behaviors which can be of primary importance when building a relationship of trust (see Egan, 1975).

While the therapeutic technique utilized in the overall pilot program primarily focuses on a cognitive-behavioral framework, during the first session the clinician employed a methodology commonly associated with non-directive forms of psychotherapy. Thus, by using the skills of primary level accurate empathy (Egan, 1975), the clinician attempted to communicate that he understood the nature of the students' conflicts as they relate to the pressures of the Medical Assistant Program. According to therapists who underscore the importance of a therapeutic "atmosphere," the presence of empathic understanding is one of the essential ingredients in developing a trusting relationship, and one of the central conditions that can facilitate positive personality change in clients (Rogers, 1957).

In validating the clinician's intentionalities, the practitioner appeared to: (a) accomplish his objective of introducing students to the theme and purpose of the workshop, and (b) create a climate in which students might become better acquainted with him. The clinician's narrative provides evidence that he was able to generate a climate of trust through spontaneous self-disclosure, genuine caring and positive regard for the students, as well as an accurate understanding of the conflicts facing them.

SESSION TWO: OF CHICKENS AND EAGLES

A. Objective

1. To introduce the concept of self-esteem.

B. Curriculum Outline

1. Classroom exercise: List all of the things you like about yourself.
   a. How did you feel at the start of, during, and at the end of the exercise?
   b. How do you feel about what you see when you look at yourself?
   c. What do you like about yourself? What don't you like about yourself?
2. The early socialization of women. How we come to feel the way we do about what we are like.
   a. Ways in which we rate and rank ourselves.
   b. The game of "contrast and compare."
   c. The fear of not being perfect.
3. The three life positions:
   a. I'm not OK - You're OK.
   b. I'm not OK - You're not OK.
   c. I'm OK - You're not OK.
4. Discussion of parent/child/adult tapes.
   a. The influence of the parent, child and adult tapes on assertive behavior.
5. Curing the "Chicken Complex" and becoming an "Eagle."
   a. Unearthing the child and confronting your NOT OK position.
   b. Learning to accept yourself.

c. Respecting yourself.

d. Loving yourself.

e. Liking yourself.

6. Take home exercise: ME! An exercise in getting to know myself better (see Appendix A).

C. Primary Sources of Instruction

1. Chenevert, M. (1983).

2. Harris, T. (1967).

D. Clinician's Narrative

My intentions were to talk to the group about self-esteem. I decided to get the students to think about this concept by having them make a list of all of the things they liked about themselves. We then talked about how they felt about doing the exercise and what they had observed about the others doing it. I asked the students why it might be easier to think about things they didn't like about themselves. They then talked about how they had not been brought up to "blow their own horns." Others talked about how other people had put them down throughout their lives.

When I brought up the proposition that maybe we had trouble listing things we liked about ourselves because most of the important people in our lives focus on our limitations and tend to judge and criticize us, some of the students shook their heads as though it did not apply. This was the first indication of a long series of resistances that followed. It became clear that some of them didn't want to identify with what I was saying.

We then moved from their having trouble thinking in terms of lowered self-esteem to their having trouble admitting that they were feeling pressure. They talked about how they had been prepared for the worst by personnel in the Medical Assistant Program (i.e., "that the program was going to be so difficult"), and that their comments had put the students under a great deal of pressure. They talked about how they felt about the fact that they had been "singled out" for this pilot program. They wondered why they and not the others before them. They sounded defensive and so I talked to them about looking at the experience as providing them with an added dimension rather than one that underscores any deficiencies. They wanted to test me to see how I would react to their assertiveness (in a few instances, it came closer to mild aggressiveness). I shared with them why I had concluded that there was a need (based on prior counseling of Medical Assistants and previous needs assessments) and challenged them with the responsibility of carving something worthwhile out of the reality that had been handed to us. The only must was that they had to be there--the rest was up to us.

I feel that although I was unable to stick to my script, the interactions, as well as the discussion, were congruent with the initial objective of the session: looking at the issues of how we act when we are wondering whether we're OK, and how we act when we do take a chance to express our likes and dislikes, our feelings and needs, and our self-esteem is not diminished in the process.

E. Researcher's Validation of Instructional Intent and Comments

As noted in the clinician's narrative, the program format could not be followed because of a provocative question raised following the initial classroom exercise. Students became very resistant, frequently creating distractions which at several points interrupted the group interaction (e.g., giggling). Voice quality, as well as word usage, suggested that many of the group members had assumed a defensive position. What is significant, however, is that what had initially been intended as a pragmatic and didactic approach to helping students learn about self-esteem became an opportunity for them to experience it. In this respect, students began to respond to provocative questions which were closely related to their feelings of self-worth (e.g., "How do you feel about being 'singled out' for this pilot program?" "We feel like there is something wrong with us!").

As the students continued to openly and assertively (albeit, in most cases, aggressively) discuss their objections to their involvement in the pilot study, the clinician remained calm and continued to employ those techniques which would perpetuate additional self-disclosures on the part of students. In this regard, the clinician used active listening skills which paraphrased and clarified students' responses, and provided positive reinforcement to those who participated by responding with "Uh huh," "OK," or words like, "Thanks for sharing that idea," or "I'm glad you mentioned that." His responses to students' remarks were always warm and friendly, and when his perceptions appeared to differ from

those of a student, he would underscore that there are no "right" or "wrong" answers, there are simply different perceptions. The clinician would respond to a perception in the following way: "While I can appreciate your perception, I would like to let you know what mine is about that issue." Hence, both the clinician and students were permitted to share their own personal feelings and cognitions without the threat of recrimination and subsequent embarrassment. In addition, the clinician maintained his position as an integral part of the group by frequently referring to the group as "we."

As students began to reveal their personal feelings and became more argumentative (possibly as the result of a displacement of emotions of hostility, anxiety and aggression), the clinician remained calm and continued to communicate accurate empathy and respect toward the group members. At one point he stated, "People are often frightened off by the idea of therapy. They ask me if there is something wrong with them or why would I need it? My particular point of view is that we could all benefit from personality expansion . . . . I like to look at this as a plus, something extra, and not something necessarily that you have got to have because of some deficiency." The clinician went on to say that he was glad that the issue was brought up because he and the students obviously had differing perceptions about the reasons for conducting the pilot program.

Two very important issues emerged from this session. First, students were making faulty assumptions about the pilot program which were creating feelings of hostility and dissonance. Because

predictability is a necessary ingredient in a social interaction, and trust can develop only if faulty assumptions are replaced by accurate information (Miller & Nunnally, 1970), the clinician facilitated the feelings of trust by providing feedback regarding his own beliefs, feelings and meanings associated with the pilot program. In this regard, as the students asserted themselves to check out their personal perceptions, they received feedback from the clinician that provided a baseline of shared meanings for all of the group members.

In addition, during this session a resistance emerged which appeared to be associated with students' fearful expectations and faulty assumptions about the reasons for their involvement in the pilot program. According to group process theory, during the initial stages of groups it is not unusual for group members to feel doubtful as well as suspicious of the group leader (Corey & Corey, 1977). In this case, the students also seemed to be suspicious of any personnel who might have been behind the promotion of a project for which they neither had time nor felt a need (particularly because they weren't "being graded yet have to be here"). The clinician acknowledged their fears, anxieties and perceptions, and encouraged students to explore and share their feelings without coercing them into doing so (e.g., "While I would like you to share with us how you feel, disclosure is not necessary. You don't have to."). The clinician continued to maintain a nondefensive posture, warmly encouraging students to participate by asking his audience, in general, "How do you feel about that?"

When students chose to participate, the clinician, without exception, always offered some form of positive verbal response. In addition, he continued to frequently remind students that it is "OK to differ in perceptions from one another." In this way, the clinician allowed students to openly explore feelings associated with personal perceptions in an atmosphere that would not devalue their sense of self-worth.

SESSION THREE: OF CHICKENS AND EAGLES (Cont'd)

A. Objectives

1. To continue the discussion of self-esteem.
2. To introduce self-concept principles.

B. Curriculum Outline

1. Classroom exercise: Describe yourself to yourself. Make a list of what you are like.
   a. What are you like? What do you see when you look at yourself?
   b. How did you come to feel the way you do about what you are like?
2. The relationship between self-concept and self-esteem.
   a. How are the concepts alike?
   b. How are the concepts different?
3. The origin of self-concept and self-esteem.
   a. Self appraisals are reflected appraisals (i.e., self-perceptions of others' perceptions).
      (1) Perceptions are derived from the mannerisms, appearance, voice quality and the content of verbal communications of those with whom we relate.
4. Additional self-esteem issues.
   a. What are some questions we need to ask ourselves when we look candidly at our self-esteem?
   b. What factors contribute to a low self-esteem?
   c. Is self-esteem immutable or can it be changed?
      (1) What can be done to raise a person's self-esteem?

(2) Why is it so difficult to raise a person's self-esteem?

d. The importance of self-esteem.

(1) A discussion of Abraham Maslow's pyramid of human needs.

(2) A variation of Maslow's pyramid: Chenevert's hourglass of human needs - a bottleneck at self-esteem.

e. The capacity to love: to be love-able, one must first be loveable.

(1) Other-acceptance first requires self-acceptance.

5. The Chicken/Eagle continuum.

C. Primary Sources of Instruction

1. Chenevert, M. (1983).

2. Maslow, A. H. (1970).

D. Clinician's Narrative

During session three I wanted to make sure that the students knew the differences between self-concept and self-esteem, so we reviewed the terms and our understanding of them. They did very well with these.

Next, I wanted them to think about how the two concepts (self-esteem and self-concept) are closely related. I asked the students to reflect back to the classroom exercise in which they made a list of things they liked about themselves. I suggested that if what they put down on the list related to those qualities they "see" when they look at themselves, they are talking about self-concept. Conversely, if the students listed items they "feel" about themselves, they were reflecting self-esteem perceptions. I shared that a person

with a low self-concept is likely to have a low self-esteem, and people with healthy self-concepts are likely to experience high levels of self-esteem.

We then talked about where self-concept and self-esteem come from (e.g., from our perceptions of others' perceptions of us). I then introduced the students to the four aspects of a person to which we pay close attention when we are perceiving, and I operationally defined each. Appearance: what we see of a person that doesn't move. Mannerisms: what we see of a person that does move. Voice quality: how a person says what he says. Voice content: what a person says. The group decided that voice quality was weighted most heavily.

We talked further about self-appraisals as reflected appraisals and of how we couldn't get around the importance of others' perceptions of us since we are fixed in interpersonal space. In order to personalize the self-esteem concept, I asked students to consider their own levels of self-esteem. This they did and most of them concluded that they were not satisfied that their self-esteem was high enough and that their self-esteem seems to vacillate a lot. They did agree, however, on a baseline idea (which they thought could be higher).

I then asked the students to consider the question: what contributes to a person's low self-esteem? The students then shared how failures bring a person down, as well as put-downs and criticisms. This moved us into a discussion about what they might consider doing to raise another individual's self-esteem. I chose

to have the students think about other people's self-esteem because I thought it would be easier for them to consider another at this point rather than themselves. This technique worked, and there were many testimonials about family members with low self-esteem levels. A discussion ensued related to why it is so difficult to raise another's self-esteem. I shared with the students that it is a circular proposition (like depression): people with low self-esteem levels almost need to feel worthier before they can do what will help them feel worthy. We then talked about how it brings people down to be compared unfavorably with others.

Next we looked at why self-esteem is important and discussed Maslow's hierarchy of needs. I shared with them a somewhat different version of the human needs pyramid by describing Chenevert's hourglass variation. I explained that I would put the bottleneck of self-esteem before the love and belonging level. I wanted to impress upon them how loveableness is necessary for love-ableness to occur. I also conveyed to the students how other-acceptance comes after self-acceptance, and how important it is that we experience love from someone in order to be put in touch with our capacity to love.

I then wanted them to think about where they were on the self-esteem continuum; therefore, I asked them to consider whether they were "chickens" or "eagles." We then brainstormed the characteristics of chickens and eagles which offered a number of revealing traits related to people:

Chickens	Eagles
Lay eggs	Seek out eggs
Kept	Free
Domesticated	Spirited
Dependent	Aggressive
Afraid	Independent
Weak	Unafraid
	Strong

Following the exercise, I spoke about the Chicken-Eagle continuum and asked the students to place themselves somewhere on that continuum in their minds.

I concluded by reading James Aggrey's "The parable of the eagle" for inspiration (as paraphrased in Chenevert, 1983, p. 2).

E. Researcher's Validation of Instructional Intent and Comments

The tapes demonstrate that the clinician did indeed accomplish his major objectives of familiarizing students with self-concept and self-esteem issues. The curriculum was followed as outlined and appeared to provide an effective cognitive framework for communicating the primary points.

Beyond the dissemination of knowledge, however, special features of the session provide a more comprehensive understanding of group dynamics and therapeutic methodology. By way of illustration, during the session, students tended to use the word "should" with high frequency, which, according to the basic tenets of Rational-Emotive Therapy, can be symptomatic of an irrational belief system and

constitutes a major source of anxiety for individuals. Consistent with techniques utilized by Rational-Emotive therapists, it is important to confront the erroneous beliefs in order to curtail further self-defeating, self-indoctrination. In this regard, the clinician does not attack the person, but rather the person's belief system by employing an active-directive-persuasive-philosophic methodology (Ellis, 1973). During the third session, the use of Rational-Emotive Therapy principles became necessary when a student stated, "I wonder if my self-esteem is where it should be." The clinician replied with a slight chuckle, "When I hear the word 'should' my ears pick right up because, wow, what are 'shoulds?'" The clinician explained that "shoulds" are like ideals, and they imply that we are being very hard on ourselves and not being very realistic about our expectations. It is noteworthy, that when the clinician was responding to the student's statement he communicated his response to the entire group and his message conveyed a warmth that appeared to make his indirect form of confrontation even less threatening. In this regard, humor, generalization of response of a confronting nature to the larger group, and mutual trust and caring are very important ingredients when regulating the intensity of confrontation, particularly during the early stages of the formation of the group (Gazda, Asbury, Balzer, Childers, & Walters, 1977).

The clinician continued to listen empathically to students' responses; however, the frequency of his use of questions increased. The tape reveals that while reflective statements tended to have a liberating effect upon students and encouraged more discussion

(e.g., "Sounds like he is getting an awful lot of attention from all of this."), closed questions (e.g., "Is he getting a lot of attention from all of this?") appeared to inhibit disclosure. There is substantive evidence that as the clinician began to increase the frequency of his inquiries, students began to respond with less frequency. The clinician's questions appeared to exert an inordinate degree of control over the direction in which the discussion was moving, and the "Why?" questions, in particular (e.g., "Why is that?"), seemed to force people into justifying their cognitions and feelings. Further, because the clinician did not allow sufficient time for the students to ruminate about his questions, he provided little opportunity for in-depth introspection. In addition, as the clinician continued to ask questions, for which he received no feedback, he began to answer his own questions, which, according to psychosocial learning/conditioning principles, may have reinforced silence. Providing answers also appeared to give the perception that there existed a "right" response to each question. Such a scenario, according to Gazda, et al. (1977), can create a dependency relationship between members of the group and the clinician, and can affect group members' acceptance of responsibility to share their own perceptual worlds. It would be further conjectured, that the frequency of use of questions, as well as the specific type of question being asked, may have contributed to the genesis of nonparticipatory behavior among group members who, according to the clinician's taped comments, he was beginning "to lose."

It is of interest that during this session certain "personality types" began to emerge. It would be suggested that the group

"protagonist," the group "clown," the group "nonconformist," the group "monopolizer," and the group "seductress" were all beginning to materialize. As noted, the group "nonparticipants" also were beginning to surface, and, while these members regularly attended the workshop sessions, according to the clinician's taped comments, the subgroup appeared to possess its own standards for acceptable behavior (e.g., whispering during group discussion and the clinician's lectures). While a case might be made that nonparticipatory behavior does not necessarily equate with lack of involvement in the group process, it can signal a problem of resistance. Further, disruptions evinced by a subgroup can thwart attempts by the clinician to create total group cohesion. It would be suggested, therefore, that had these students been invited to explore what their nonparticipatory behavior meant during the early sessions of the workshop, the likelihood of future involvement might have been enhanced.

SESSION FOUR: PIGEONS

A. Objectives

1. To introduce the concept of manipulation.
2. To discuss each form of manipulative ploy, why it works so well, and what can be done to counteract the ploy.

B. Curriculum Outline

1. Manipulation defined.
2. A discussion of manipulative ploys.
   a. Flattery.
      (1) The implications of being "buttered up."
   b. Criticism.
      (1) The relationship between criticism and NOT OK feelings of self-doubt which affect our self-esteem.
   c. Insecurity.
      (1) Fears associated with our feelings of insecurity: fear of withdrawal of affection, fear of being left alone, fear of what people will think, fear of offending someone.
   d. Helplessness.
      (1) Reasons why the "rescue complex" can backfire.
   e. Obligation.
      (1) The difference between sharing your life with another and giving your life to another.
   f. Guilt.
      (1) The sister to obligation; guilt makes us susceptible to all types of manipulation.

3. Anger: The appropriate emotional response to the perception of being taken advantage of, or being used.
   a. What happens when you swallow your anger?
   b. What happens if you spit your anger out?
   c. What happens when you try to "fight fire with fire?"
4. Hurt: An inappropriate conditioned substitute for anger when being taken advantage of, or being used.

C. Primary Source of Instruction

1. Chenevert, M. (1983).

D. Clinician's Narrative

My intentions were to make the students aware of the ways in which people were manipulating them. We talked about how people are often "pigeons" that are susceptible to the ploys of flattery, criticism, insecurity, helplessness, obligation and guilt. In each case I discussed with them what form these ploys take, why they work so well, and what can be done to counteract them. They listened, reacted, gave insights, cited personal examples, reinforced each other's responses, and enjoyed themselves. I believe I was able to get my points across by depicting the ploys in graphic terms to which they could relate as people who have experienced the various types of manipulations. We discussed the realities and practicalities of why these ploys are so effective with them. I gave them concrete, useful, pragmatic ideas to think about and try which I felt would counteract the manipulation's effectiveness. This was a subject to which they could really relate.

I then spoke to the students about the predominant response to manipulation - anger, and we talked about what they customarily do with their anger (e.g., swallow it, spit it out), and what the implications of these responses may hold for them. It was at this point that I alerted them to still another alternative to manipulation: assertiveness. I mentioned assertiveness only in passing because I first wanted the students to focus on what "pigeons" have been known to do in retaliation to manipulation, e.g., engage in their own brand of manipulation (which falls short of healthy assertiveness). This notion of how "pigeons" manipulate back when they are being manipulated will be the subject of the next session. In particular, we will discuss what an inappropriate response to manipulative ploys ultimately does to our self-esteem and why assertiveness is a far healthier alternative.

E. Researcher's Validation of Instructional Intent and Comments

The tape confirms that the clinician presented the curricular issues which he had intended.

During this session, the clinician employed a new technique which began to alter the amount of student participation dramatically. In this regard, there were very few instances in which the clinician used "Why?" questions. Instead, he presented small portions of the curriculum and had students then provide sentence completions (e.g., "Pigeons" (people) are a little too _____). While the "correctness" of the answer still appeared to follow the clinician's "script," judging from the frequency of their response, the students seemed to enjoy this type of inquiry. More striking, however, was

the amount of discussion generated by the clinician's use of open-ended questions. Accordingly, and as suggested previously, inquiries that began with the word "what" prompted a great deal of discussion, particularly when the students could identify with the subject matter (e.g., "What can we do to counteract criticism from others?").

In addition, the clinician did not prepare such an energetic curriculum plan for this session. Perhaps as a result of a more realistic format, the clinician experienced less pressure to get through an elaborate text. It would be suggested that he was far more relaxed during this session; he laughed aloud more frequently, was more spontaneous in his responses to students, and assumed less responsibility for the direction the discussion was taking.

Because a great deal of disclosure emerged during this session, it became apparent that group members were at different developmental stages; hence, students appeared at variance with respect to their experiential bases. Examples of these differences were communicated in the following comments: "Being a parent, I . . ."; "My mother always . . ."; "I just love Rod Stewart"; "My husband . . ."; "My boyfriend . . ." It is noteworthy that the clinician effectively used the skill of "linking" (Corey & Corey, 1977) to create a supportive interactional environment. In this sense, "linking" encouraged students at one level to respond to, reinforce, and help students at another. As Knowles (1980) has posited, a problem-centered orientation to learning can cut across age, marital status and other characteristics which make people different, and effective facilitators of adult learning encourage students to make use of the rich reservoir of experiences of all of the adult learners within

the learning environment. Accordingly, the clinician provided the opportunity for learners to apply the past experiences of other group members to their own experiential bases, thereby making the process of learning more meaningful and integrated for those seeking problem resolution.

SESSION FIVE: MANIPULATION AND ASSERTIVENESS

A. Objectives

1. To discuss the inappropriate, indirect methods of dealing with the anger which results from feeling manipulated.
2. To introduce the concept of assertiveness.

B. Curriculum Outline

1. Inappropriate methods of "getting even."
   a. Bitching.
   b. Ignoring.
   c. Sniping.
   d. Forgetting.
   e. Procrastinating.
   f. Lateness.
   g. Sabotage.
2. Steps toward handling anger.
   a. Stop running away.
   b. Give yourself permission to be angry.
   c. Don't deny and try to hide your true feelings.
   d. Face the person making you miserable.
   e. Acknowledging and accepting your weaknesses and strengths.
3. Assertiveness: The healthy response to manipulative ploys.
   a. Assertiveness defined.
   b. The goal of assertiveness.
   c. Important questions to ask yourself when learning to be assertive.

d. Facts about assertiveness.

(1) Early socialization results in male-female differences in assertive behavior.

4. "Looking for Space" (by John Denver).

C. Primary Sources of Instruction

1. Chenevert, M. (1983).

2. Taubman, B. (1976).

D. Clinician's Narrative

My intention was to get the students to think about how they felt about getting manipulated - about being "pigeons." We talked about anger and what "pigeons" are prone to do with it: swallow it, spit it out, or resort to devious, indirect methods for "getting even." They seemed to identify with some of the methods, especially ignoring and procrastinating. We talked about how assertiveness can help them discharge anger without going to the extremes of homicide or suicide. We then discussed the steps involved in handling anger appropriately. I explained that the first step is to stop running away, give themselves permission to get angry, and not deny nor try to hide their true feelings. I went on to explain that the next step is to face the person making them miserable and be willing to look and listen, and acknowledge the other's presence, feelings, and opinions. To stop being a "pigeon" they have to know what their weaknesses are. A second line of defense discussed related to the area of strengths, because manipulators play upon these as well.

At this point, I introduced assertiveness as the healthy alternative to manipulation and defined assertiveness as the expression of their

own feelings, wants and needs, learning to act upon them and having respect for the feelings, wants and needs of those around them. We then talked about male-female differences regarding assertiveness and I read to them an excerpt taken from the book, How to become an assertive woman (Taubman, 1976, p. 6), that makes the point that at an early age men are taught they can manage their environment - women are taught they have to play with the cards dealt them.

We then considered some of the questions that those learning assertiveness ask themselves: "What do I want? What do I need? What do I need to ask for? How can I ask for it without making a demand? How can I make it clear that this is important to me?" We then talked about how assertiveness is not a guaranteed road to happiness - but a trip that is necessary! I ended the session with John Denver's "Looking for Space" (cited in Chenevert, 1983, p. 116) to give them food for thought about what they were going to do with their lives.

This session did not get the level of participation and enthusiasm that the previous sessions had obtained. I think the fact that the students had just received the results of their first lab test the period before probably had something to do with this. They seemed distracted; some looked like they were in shock. This made me think that perhaps in future sessions I should allow a little time up front to discuss what has been happening with them. I would then try to tie some of this in with the "topic" for the day.

E. Researcher's Validation of Instructional Intent and Comments

The tape reveals that the clinician followed the curriculum as outlined; however, because he perceived the students to be experiencing

frustration, he frequently departed from the program format to acquaint them with a number of personality factors and psychological principles. He effectively interfaced the subject matter he had intended to present with a discussion about repression, passive-aggressive personality characteristics, and the frustration/aggression hypothesis and related these precepts to the behaviors being evinced by the students. By exploring openly what was happening in the here-and-now, the clinician provided the students with the opportunity to more clearly understand how they were feeling and what they were doing in response to their feeling states. According to Egan (1975, p. 178), immediacy is called for when the clinician "sees that either he or the client has unverbalized thoughts and feelings about what is taking place in the helping session that are getting in the way." In this regard, the clinician stated, "Today, I was picking up some signs of your being angry because you have been frustrated. And now what will you do with your anger?" A student responded, "I'll take it out on the accelerator!" Hence, the use of immediacy elicited one of the few responses during the session, which, in turn, the clinician used to address the notion of displacement and subsequently talk about the healthy response to anger: assertiveness. He tried to impress upon the students that it was "OK to be angry."

The students were very unresponsive, which might have been very threatening and frustrating to an inexperienced clinician. In this case, however, the clinician used the circumstance to model assertive behavior. At one point, he painstakingly asked the same question in three different ways and continued to receive no response. His voice quality gave this researcher the perception that he was

neither angered nor frustrated by the students' apparent resistance. Soon afterwards, the clinician appropriately explained that assertiveness is two-fold: it requires that the person be able to express his or her own feelings, wants and needs, but acknowledge the feelings, wants and needs of others, as well.

As the clinician suggested, it is plausible that the students were reacting to the lab test grades they had received, and their very low scores presented them with a noxious stimuli to which they were responding with a form of denial. During the second session, it is recalled that the students had pointed out to the clinician that they had been placed under undue pressure by personnel who told them the course was difficult when, in fact, it "is fun." Students had now reality-tested their earlier cognitions only to find them incongruent with what they were experiencing. Given the antecedent events, it appears that the timing was excellent, albeit not purposed by the clinician, to discuss "getting even" mechanisms.

In addition, it is noteworthy that at this point in the Medical Assistant Program students generally become very anxious and prone to "bitching" and "sniping" in response to difficult tests and the stresses inherent in the program, in general. As this group progressed through the program, however, teachers communicated to this researcher that it was a "very pleasant group of young women," a comment that was to be expressed repeatedly. Perhaps the group intervention had begun to impact upon students by the time they received their first grades, and they were able to cope more effectively with their anxieties, frustration and anger.

SESSION SIX: TARGETING YOUR ASSERTIVENESS DIFFICULTIES

A. Objectives

1. To introduce the concept of the "neurotic spiral."
2. To describe and discuss the signs associated with a descending "neurotic spiral."

B. Curriculum Outline

1. The "neurotic spiral" defined.
2. Signs associated with a descending "neurotic spiral."
   a. Placating others.
   b. Being easily maneuvered.
   c. Inability to express legitimate wishes.
   d. Devaluing your own rights, overvaluing the importance of the rights of others.
   e. Feeling self-conscious in the presence of authority figures.
   f. Being easily hurt and self-inhibited.
   g. Feeling miserable without knowing why.
   h. Feeling pushed around because you have never learned to stand up for yourself.
   i. Feeling lonely because you have no close relationship.
   j. Feeling inferior because you don't utilize your potential.
3. Reversing the spiral.
   a. Change your behavior and your thoughts and feelings will change.
4. Resist the temptation to generalize when things don't work out: Pinpoint your assertive difficulties.

C. Primary Source of Instruction

1. Fensterheim, H., & Baer, J. (1975).

D. Clinician's Narrative

My intention was to talk to the students about the "neurotic spiral"and to relate this notion to their particular situation in the Program. The "neurotic spiral" refers to the downward trend that sometimes occurs when one's behaviors are perceived by others and by self as inadequate. These inadequate behaviors are followed by self-doubts and disturbed feelings which in turn spawn more inadequate behaviors and so on. As a case in point, I used getting a low score on an exam or discovering that one is not doing very well thus far in the Medical Assistant Program. This opened up a lot of discussion because a three-week evaluation had gone out to about one-third of the class. A more than usual amount of participation followed. One student disclosed her letter, another talked about her mixed feelings about the policy of sending evaluation letters (to those not doing well) so early in the Program. The student felt it was too soon to let people know about themselves and yet she granted that if they were able to do anything about things, the sooner they knew, the better. Another shared that she felt everyone should receive a letter so that students who were failing would not be "singled out." I tried to shift the emphasis from talking about what should be, to discussing what can be done with the hand that's dealt us.

I believe it was important for the students to ask themselves the questions, "What does this mean?" and "What does this not mean?"

I also believe that it was important for me to help them resist the temptation to generalize and thus to perpetuate the "neurotic spiral." We talked about our tendency to do just that (i.e., to generalize about ourselves when something happens to us), and discussed how we might try to change this self-defeating pattern.

Students began to talk about what they got, and did not get, from people when they confided in them, shared with them and disclosed to them (e.g., parents and spouses). Some shared that they felt judged by others who tended to see the "bug on the windshield"; others got their accomplishments taken for granted; others only got positive reinforcement when they were needy and felt that those whom they loved found it difficult to rejoice with them.

We got no further with the prepared program than the "neurotic spiral"; however, I feel what they wanted to talk about was more important than the new material which was to be presented.

E. Researcher's Validation of Instructional Intent and Comments

As the clinician's narrative reveals, he did not move beyond his introduction to the concept of the "neurotic spiral." Beyond that which is already documented in his narrative, however, there are some significant issues resulting from the social interactions within the group.

The clinician's perceptions from the previous session indicated the need to let students vent their feelings. He allowed time for this at the beginning of this session, and many personal disclosures were heard. While the students continued to demonstrate that they were unable to speak about themselves personally (i.e., each spoke

about concerns as though they were shared in common by all members of the group), they did provide this researcher with some useful information regarding Medical Assistant Program policies. (Their concerns about the three-week progress reports, and how they are distributed, will be evaluated in the future to determine whether there is a more effective way in which to handle student appraisals.) In accordance with studies which underscore the desirability of program evaluation, the gathering of formative information of this nature can be very valuable feedback in assessing the efficacy of existing programs and in improving the delivery of services in these programs and ensuring that the program is sensitive to the needs of its recipients (Posavac & Carey, 1980).

The tape provides supportive evidence that the students were very upset, anxious and fearful about being evaluated. The clinician emphasized to the students that they must look at the reality of the situation (i.e., "What does it mean? What does it not mean?"). He stressed how faulty assumptions, based on limited knowledge (e.g., "I'm going to fail the course because I received a progress letter"), can trigger the "neurotic spiral."

Throughout the session, the therapeutic technique employed was couched in the principles of Reality Therapy. The clinician communicated caring, did not evaluate, focused almost exclusively on students' present behaviors and stressed the importance of seeing themselves accurately and facing reality. The clinician emphasized one of the hypotheses central to Reality Therapy: if we want to change what we <u>are</u>, we must begin by changing what we <u>do</u> and undertake new ways of <u>behaving</u> (Glasser & Zunin, 1973). The

clinician would not permit the students to talk about what the three-week policy "should" be like, but encouraged them to face the reality that this is the policy, and "What are you going to do about it?"

At one point during the session, the clinician found the students unresponsive, and he tested the reality of his own earlier perceptions by reflecting back to the previous session and stating, "It was really hard to get you to be with me that day, and I think it had something to do with the test you took that day. You were in shock, some of you." This comment was vigorously confirmed by the students. He then explained, "We cannot ignor the realities of what happens to us before we get together, because if we do, you're just going to push me away. We had better talk about it and deal with it." A very spirited discussion followed; however, it appears that the clinician was still aware of the nonparticipating subgroup members when he said, "I am concerned about those of you who are not yet able to talk about this. Do you need us in any way?" He went on to say, "People who take a chance to disclose will be in better shape because they are getting support." His remark once again elicited a great deal of discussion; however, it is unknown to this researcher whether the clinician had "reached" those to whom he had addressed the remark.

The students seemed to have an intense need to release pent up energy. The taped student disclosures reveal that individuals were exhibiting high arousal states (e.g., they spoke very loudly, at a rapid pace, and at several points during the session outbursts of laughter seemed to be incongruent with the comments which provoked

the response). This researcher believes that had the clinician not permitted a catharsis for students, they might have begun to engage in less appropriate, self-defeating behaviors.

SESSION SEVEN: TARGETING YOUR ASSERTIVENESS DIFFICULTIES (Cont'd)

A. Objective

1. To identify assertive problem types.

B. Curriculum Outline

1. Assertive problem types.
   a. The timid soul.
   b. The person with communication difficulties.
      (1) Indirect communication.
      (2) Dishonest or pseudoassertive communication.
      (3) Inappropriate communication.
   c. The split assertive.
   d. The person with behavioral deficits.
   e. The person with specific blocks.
      (1) Fears that inhibit.
      (2) Possession of incorrect ideas.
      (3) Misconceptions of social reality.
      (4) Erroneous ideas of psychological reality.
      (5) Inability to grant independence to others.
   f. The person with interfering habits.
   g. The person with assertive difficulties toward their children.
2. Take home exercises: Assertiveness Inventory (see Appendix B).
   Uptight Inventory (see Appendix C).

C. Primary Source of Instruction

1. Fensterheim, H., & Baer, J. (1975).

D. Clinician's Narrative

My intention was to intensify the students' awareness of where they might be situated on the continuum of assertiveness. I had previously introduced them to the concept, "neurotic spiral"; I now wanted to apply this concept to the subject of their assertiveness. To accomplish this I first gave them the "signs" to look for in assessing their own assertiveness. These "signs" all had to do with the way people are when they are being non-assertive. There were ten such "signs"; I presented each of them very slowly and deliberately so that they could introspect on the spot about the relevance of each for their particular situation.

My impression was that the students did listen attentively to the "sharing of the 'signs,'" even though there was little formal feedback. The students' verbal asides, mumblings, grunts and groans, facial expressions, head noddings and other bodily movements, all suggested that they were relating well to what I was saying.

The next topic was designed to intensify the students' introspection with regard to their own levels of assertiveness. I chose to discuss with them various "assertive problem types." I followed the same format in presenting each type for their consideration: first naming the type, then graphically describing the characteristics of that type (e.g., "The 'timid soul' . . . . you allow yourself to be pushed around, cannot speak up, remain passive in all situations, and if someone steps on your foot, you say, 'I'm sorry.'"). This last point particularly elicited a reaction from them.

As I took the students through each assertive problem type, our discussion touched upon many of the ways in which we tend not to be assertive, e.g., the person who: (a) has trouble being direct when communicating, (b) is verbally open and expressive of her feelings but has trouble showing them otherwise, (c) cannot establish or maintain eye contact, (d) does not understand that different kinds of relationships exist with different people and therefore ends up treating a stranger as a friend, or (e) has learned to do things the wrong way and therefore has trouble doing what she needs to do to change.

From the quantity and quality of discussion that ensued, I believe my intentions to sharpen their awareness concerning the state of their own assertiveness were realized. To further the students' introspection, I presented each with two inventories to take home and work on independently. The purpose of the Assertiveness Inventory was to help them pinpoint their assertive difficulties. The Uptight Inventory was intended to help students identify the kinds of things that make them anxious.

E. Researcher's Validation of Instructional Intent and Comments

At the beginning of session seven, the clinician completed all of the material remaining from the previous session. The material designed for session seven was covered according to plan.

During session seven, the clinician encouraged students to use "I" statements, and to "own" their feelings, experiences and behaviors. He stated, for example, "I would like you to get a 'fix' on whether or not you are caught up in the 'neurotic spiral.' Ask yourself if

you fit into any of the categories." In this sense, he was asking students to personalize their perceptual sets. In addition, the encouragement of concreteness throughout the entire session seemed to help students "own" their statements. The clinician modeled this behavior by offering very specific examples of his own experiences and feelings and by providing very clear examples of "signs" of assertive problem types. He also pressed for more concrete communication from students. As the tapes from previous sessions attest, students have found it very difficult to share personal feelings and behaviors. To date, their communication has been circuitous, and students have preferred to speak of the problems of others. During this session, however, the clinician gently, albeit firmly, encouraged students to be more explicit. By way of illustration, a student stated, "With some people, I can start a conversation, with some I can't." The clinician responded, "What is it about some people that you can and some people you can't?" The student replied, "I am afraid some people will get mad so I really have to watch what I say." Thus, the use of the skill of concreteness, in addition to "what" rather than "why" questions, encouraged specificity and self-exploration. Exploration of problem behaviors and feeling states associated with non-assertiveness was also effectively achieved when the clinician asked the question, "Can any of the rest of you identify with this?"

It became evident that during this session certain group members were attempting to form a personal relationship with the clinician. "You and I" exchanges became more frequent and were communicated in the form of jokes and provocative statements by students (e.g., "I

have this problem . . . ."), to which the clinician was apparently being cajoled into responding. In addition, one of the students who was beginning to elicit attention-getting behaviors with increased frequency started to interfere with group work. Had the clinician provided the student with the amount of attention she apparently was attempting to gain, it would have been at the expense of the rest of the group members. The clinician perceived the degree of distraction the student was creating, and at one point said (with a chuckle), "I'm not going to bite for this one. You go on forever! I've already discovered you!" His response did not devalue the student, but it seemed to effectively communicate that he no longer wished to attend to her inappropriate verbalizations.

While there was not a high level of participation by group members during this session, the students, according to the clinician's narrative, appeared to be attending to the discussion. This was later confirmed when, during the twelfth week of the Medical Assistant Program, this researcher presented a lecture related to job preparation. During the lecture, students were asked to provide a description of individuals who they would characterize as "professional." Students quickly provided a succession of descriptors which were introduced to them during session seven of the workshop (e.g., A "professional" is assertive, is honest, is direct, has effective communication skills, is empathic, is sensitive, is open, is confident.). It appears that a transfer of learning had indeed taken place.

SESSION EIGHT: BASICS OF ASSERTIVENESS TO HELP YOU GET STARTED

A. Objective

1. To help students think more personally about themselves.

B. Curriculum Outline

1. Classroom exercise: "Who Am I?" List ten things which define you.
2. Basics of Assertiveness.
    a. Compliments.
    b. Flashing red lights.
    c. Listening to yourself.
    d. Learning to relax.
    e. The calm scene.
    f. Keeping on your "assertiveness center."
    g. Get ready, get set--start!
3. Take home exercise: Ten-year Life Plan.
    a. Start small.

C. Primary Source of Instruction

1. Taubman, B. (1976).

D. Clinician's Narrative

My intention was to get the students to think more personally about themselves. I thought that they first needed to be shown their tendency to want to define themselves with reference to other people.

I accomplished my intention by having them write at least ten answers to the question "Who Am I?" and then having them look over

their list to see whether they had defined themselves mostly in terms of others (i.e., "I am Mrs. John Jones") or mostly in terms of themselves (i.e., "I am Susan Jones").

I then moved on to discuss a few basics of assertiveness with them. Each of these basics was presented as something to think about, talk about, and do something about. We talked about what we do with compliments that may translate into ideas about how assertive or unassertive we are. (The assertive person accepts compliments graciously, usually with a simple "thank you." The assertive person also gives compliments; therefore, I asked each of the students to give a compliment to someone she saw regularly. Giving compliments helps being noticed, and provides the opportunity of giving an opinion and taking responsibility for it.)

I discussed the notion of "flashing red lights" that should go off in their heads whenever they catch themselves using "qualifiers" in their conversation such as, "I don't suppose you would like to . . ." or "Do you suppose we could . . ." (I asked the students to keep track of qualifiers and negative words and phrases they directed at themselves.) I told them about what I sometimes have my clients do (who have negative self-concepts): I have them wear a rubber band on their wrist and snap it each time they put themselves down and immediately say something positive to themselves.

I then talked to them about the importance of listening to themselves. I suggested that they tape record their side of a telephone conversation over a three-day period and then play it back and listen to their voice content (what they said) and voice quality (how they said it). I wanted them to become more aware of how they are

communicating to others and help understand the ways in which they change depending upon the situation and the person to whom they are speaking.

Next, I talked to them about the need to relax and how this related to assertiveness, i.e., how difficult it is to deal with criticisms when one is uptight and anxious. I explained a technique for relaxation called "the Calm Scene" in which they envision an experience from their past in which they felt they were really being themselves. I asked the students to re-live that experience with all their senses and feelings a few seconds before they were to try to deal with whatever was confronting them. I asked each to think of her Calm Scene and to practice using it when faced with a stressful situation.

I then talked to them about keeping on their "Assertiveness Center." I wanted the students to imagine a core of security that runs straight through their body, through their spine - a core that physiologically represents their right to be who they are and what they are. And I wanted them to think about their options when they were being confronted by another: (a) to cringe back (submissive behavior), (b) to step forward to attack (aggressive behavior), or (c) to first take a step backward and then move to the center and respond without anger (assertive behavior).

Next, I talked to them about the importance of their not just thinking about these things, but doing them as well. I asked them to do one more exercise at home in which they were to write a description of their life ten years from now. (I told them to be as fanciful or as realistic as they wished, not to go overboard, but to

use fantasies). I wanted them to project their Life Plan into the future hoping that some of their new behaviors may follow suit.

Finally, I reminded them that learning to be assertive was to learn a new skill. I advised them not to tackle the most difficult person in their life to start with, but rather to start small, go slowly, not force anything, and to take small steps.

E. Researcher's Validation of Instructional Intent and Comments

The clinician covered the curriculum as planned; however, he frequently digressed from the script to provide additional cognitions which appeared to be congruent with the subject matter. For example, he discussed the concept of Allocentric Perception (i.e., the way in which people can experience life with all of their senses, which is particularly helpful when a person feels anxious), and related it to his discussion of the "calm scene." The clinician also discussed the notion of "self-talk," which is axiomatic to the work of Albert Ellis, and spoke of the ways in which self-defeating, self-deprecating remarks relate to self-concept and self-esteem. The clinician also continued to openly disclose the feeling states associated with some of his own personal experiences (e.g., how he felt when he completed his own Life Plan several years ago).

This researcher finds it rather striking that when students were asked to complete the "Who am I" exercise, at the beginning of the session, at least two students asked, "Would you give us an example?" Such a question seems to suggest that: (a) a number of students were unable to risk performing independently, and underscores that compliant behavioral patterns may exist relative to this type of

exercise, (b) some students were still looking for the "right" answers, and (c) those students seeking "right" answers wanted the clinician to provide them. The clinician did not indulge the students by providing "answers" because any response from him would have created a perceptual set which would have biased the students' personal definitions. Instead, he mentioned that he didn't want to influence their responses, which placed the responsibility where it seemed to belong: in the hands of adults who were capable of freely choosing their own self-definitions. After a short period of time, the clinician "checked in" with the students by asking, "How are you doing?" which seemed to convey the message: "I can't do the work for you, but I am still with you." A number of students at this point confided, "It is hard coming up with ten answers." This response would suggest that for many of these people this exercise provided a new kind of experience, i.e., looking in-depth at their phenomenological selves. In this respect, the exercise permitted students to purposefully look at their subjective perceptions of self in the "here and now," and many had trouble doing this.

If one were to apply the Verbal Interaction Category System (cited in Schmuck & Schmuck, 1979) to analyze the classroom verbal exchanges during this session, it would become clear that verbal communication was essentially teacher-initiated. What is significant, however, is that when students did communicate their feelings and experiences, most of the verbalizations were student-initiated. Students were beginning to ask more questions of the clinician, and were beginning to speak more frequently in the first person. One

student shared, "I do that all the time . . . and it's really hard to change." In another case, when the clinician asked a question of one of the students, the response was a very assertive, "Sure!"

Although the session appeared to be couched in a didactic approach to information-giving, when the clinician interacted with the students, he continued to utilize effective helping skills. While the frequency of use of verbal reinforcement became more intermittent, the clinician continued to use paraphrasing, linking, concreteness, and self-disclosure as primary helping skills. Because students were personalizing their feeling states with greater frequency, and a great deal of risk was involved in sharing some of these personal perceptions, it seems that a "climate" conducive to growth and development had been established and students were now beginning to perceive the clinician as a person who they could trust.

SESSION NINE: THE EFFECTS OF YOUR ASSERTIVENESS ON THOSE AROUND YOU

A. Objective

1. To promote an understanding of the effects that assertiveness may have on others.

B. Curriculum Outline

1. Resistance from those around you.
   a. Resentment from family and friends.
2. Two vital truths about assertiveness training:
   a. The only behavior you can control is your own.
   b. People are not mind readers.
3. The implications of demanding others to change along with you.
4. Your man may feel betrayed.
5. Learning to take a risk.
6. Why should a man wash his dirty socks?
7. An apple a day.

C. Primary Source of Instruction

1. Taubman, B. (1976).

D. Clinician's Narrative

My intention was to talk to the students about the effects of their assertiveness on those around them. I addressed myself particularly to those who have been trying to be more assertive and have met with resistance, as well as to those who have been thinking about being more assertive but have been hesitating because of their fears of resistance. This seemed to include everyone except for the few who might be blocking the whole business.

I chose the format of putting interest-provoking headings on the blackboard, like "Your Man May Feel Betrayed"; "Two Vital Truths"; "Learning To Take A Risk"; et al. I then shared with them a number of provocative statements that I had prepared to go with each heading, elaborated upon them, and then asked for their reactions. I elicited more reactions from them than I had anticipated; therefore, I was not able to cover all the ground I had intended. But that was all right because their reactions indicated the relevancy of what I had presented and overall we were able to stay pretty much on track.

What was significant, I thought, was the fact that a number of students focused on parents as being the ones who were having difficulty coping with their recent attempts at assertiveness. (I had anticipated that their husbands or boyfriends would have been their chief concern.) This was true not only of those still living at home with their parents, but also of some who were married or living on their own.

My main thrust to the students had to do with letting them know that much of what they were experiencing, as they experimented with assertiveness, was normal and par for the course. I thought it important for them to hear from others that what they were going through was typical. I thought they would be less likely to give up, or back off, or get discouraged, were they to be told by me, and others in the group, that resistance to their newly discovered assertiveness is to be expected. I talked to them about ways of handling this resistance (e.g., understanding how the other person might feel, going slowly with them, reassuring them) and stressed

the importance of not acquiescing, not capitulating, standing firm, and letting others know that the "new you" is here to stay.

In particular, I stressed the two vital truths of assertiveness-training: (a) The only life they can control is their own, and (b) people are not mind readers. I talked to them long and hard about the implications of these truths, and from their reactions I got the impression that these were new concepts for them - that cognitively they understood, but behavioristically and affectively these concepts were going to take a lot of practice.

E. Researcher's Validation of Instructional Intent and Comments

The clinician did not complete all of the material as outlined because of the high level of student involvement. He was only able to complete the sections through "Your man may feel betrayed."

As the clinician's narrative points out, he attempted to involve the students in a discussion about how assertiveness may be affecting the men in their lives; however, they were very reluctant to speak about female/male issues, preferring instead to talk about interactions with their parents. On two occasions, the clinician attempted to shift the focus of the discussion from parents to intimate others; however, he encountered resistance. By way of illustration, when the students began to talk about the mistakes they make with their parents, the clinician asked, "Why is it that we keep going back to the well, come up empty, but keep going back?" He went on, "What are you looking for? Do you expect to find it? What is the probability of your getting it?" He then added, "Maybe we need to get some of these needs met elsewhere." As though in an attempt to re-direct the

discussion, a student asked, "How prevalent do you find parent/child conflict?" Once again the clinician attempted to engage the students in a discussion about adult relationships by responding, "I find it very prevalent. What I notice, however, and this is even more significant, is that they are into a parent/child thing in the relationship that they have, and I'm not talking about the one they have with their parents." While a lengthy discussion ensued regarding dominant/submissive relationships, as well as the difference between being cared for and being controlled (and how these two areas appear to relate to assertiveness), students remained relatively silent about the subject of intimate relationships and why their "men might feel betrayed."

As a result of this session, this researcher would posit that catharsis and expression of feeling from members of a group are intricately related to the subject matter at hand. In this sense, while students were eager to disclose information regarding their parents, they were very reluctant to engage in any discussion which would require disclosures of a more intimate nature. Thus, it appears that certain "high risk" issues exist, and students vary the frequency and intensity of their self-disclosures depending upon the target persons being discussed and/or the categories being addressed. This dynamic may be a function of the state of development of the group (i.e., a "readiness" must exist for group members before certain aspects of one's personal life will be revealed).

SESSION TEN: THE EFFECTS OF BEING ASSERTIVE ON THE ASSERTIVE WOMAN

A. Objective

1. To promote an understanding of the factors that often get in the way of becoming assertive.

B. Curriculum Outline

1. Getting to know you.
2. Basic human rights.
3. Knowing what you want.
4. A sense of impending disaster.
5. You are good - Believe it!
6. Dynamic you.
7. The "victim mentality."
8. Double messages.
9. Blue days.
10. If I say that, he'll die!
11. Fears that impede assertiveness.
    a. Fear of being unfeminine.
    b. Fear of rejection.
    c. Fear of consequences.
    d. Fear of loss of control.
    e. Fear of learning the truth.
    f. Fear of retaliation.
    g. Fear of authority figure.

C. Primary Source of Instruction

1. Taubman, B. (1976).

D. Clinician's Narrative

I wanted the students to focus on the things that were getting in the way of their becoming more assertive. I talked to them primarily about being afraid: about being afraid to take risks; about being afraid to tell someone that you don't like what he's doing, or not doing; about being afraid to ask for what you want; about being afraid that disaster is impending whenever you take a chance; about being afraid that you will be perceived as unfeminine if you behave assertively; about being afraid that if you disagree with a loved one, he will get angry and never like you again; about being afraid to try something new because you tend to catastrophize; about being afraid to show your anger because you might lose control.

I wanted also to point out to them the things they could do to change their old ways so that they might become more assertive. I talked to them about their basic human rights; among these, the right to refuse requests without having to feel guilty or selfish, the right to feel and express anger, the right to be treated as a capable human adult and not patronized, the right to make mistakes, et al. I also talked to the students about the common tendency to adopt a "victim mentality," i.e., believing that things happen to you (as indeed they do; however, events are often beyond one's control), and I wanted them to think about the reality of being able to control how they respond to these events.

I wanted the students to realize that it was important for their assertiveness to be aware of "double messages" when they spoke, and that they needed to say what they mean and mean what they say. I

explained that it was important for them to be congruent with their feelings; to be aware of the feeling, label it appropriately, and communicate it accurately.

I wanted the students to work on building a positive self-image and suggested to them some of the things they could do to help this along. I encouraged them, for example, to write on a piece of paper, "I am a good person and nice to be around," and keep it in their purse. I also suggested that they talk to a close friend about what they thought was unlikable about themselves and emphasized that what may be major to them may turn out to be minor to their friends. I also wanted to urge them to stop listening to the critics of their childhood. I impressed upon them the reality that they were no longer children, and that they were wiser now and knew more about the world. I stressed that old criticisms do not apply to them anymore.

I used the format of reading excerpts under each heading to the students and then soliciting their reactions. As usual, their reactions were plentiful and revealing.

E. Researcher's Validation of Instructional Intent and Comments

The clinician presented the program as indicated in his narrative. Because a great deal of material was covered, and the instructional mode was chiefly teacher-centered, less time was spent in group interaction. Although the clinician's narrative suggests that students were reactive, their manner of communicating was probably more covert than in previous sessions, because the tape suggests that verbal responses were minimal. Students appeared reluctant to interact at all with the clinician during the first twenty minutes of the

session. Students neither responded to his questions, nor openly acknowledged his quips. Students seemed to be engaging in a form of "social distancing" which appeared to manifest itself in disruptive behaviors, viz., giggling, coughing and chattering. It is noteworthy, however, that the clinician was able to alter the climate and evoke subsequent responsive behavior from students when he finally confronted a student who was laughing and asked amiably, "What are you laughin' about?" His question seemed to be: (a) an indirect method for expressing his own frustrations, and (b) a catalyst for arresting the disruptions which were interfering with his objectives. The question was worded in a way in which a sense of caring and warmth were communicated, yet it also conveyed a respect for what it was he was trying to achieve. In this regard, the clinician modeled one of the essential precepts of assertive behavior, i.e., assertion involves a mutual respect for self and others. At this point in the workshop, students may have been threatened by a more confrontive expression of the clinician's frustrations, and the trust that had been established to date might have suffered accordingly.

It appears significant that students' responses tended to become more frequent when the clinician left his "script" and casually conversed with them. This may suggest that students like to be taught less than they like to interact.

Also of interest is the finding that many students still look to the clinician for bandaid remedies. "What do you do when . . .?" questions persist, to which the clinician generally responds with a personal example of the same type of experience. In addition, when a

student is heard appealing for advice, the clinician often responds with, "Try to become more assertive."

One of the most revealing disclosures during this session occurred immediately after the clinician suggested that students write, "I feel good" on the bathroom mirror, an exercise aimed at helping students build a more positive self-image. One of the students responded, "Then I would have to clean it!" While there may have been a number of unconscious motives underlying the retort (as well as the possibility that the student possesses an obsessive-compulsive personality), her remark was rich in hidden meaning: early socialization processes have assigned a plethora of gender-appropriate behaviors to women (e.g., women are expected to wash men's dirty socks and keep bathroom mirrors clean), yet these traditional stereotypic role expectancies can impede the growth and development of women as they attempt to seek meaningful experiences. The comment appears highly symbolic of the externally imposed, and internally perpetuated, tug-of-war which women experience as they engage in the process of becoming more fully functioning human beings.

SESSION ELEVEN: ASSERTION ON THE JOB

A. Objectives

1. To introduce students to unassertive personality job types.
2. To acquaint students with the first of a seven-point guide to achieving assertion on the job.

B. Curriculum Outline

1. Unassertive job types.
   a. The pigeon.
   b. The person in the background.
   c. Your own worst enemy.
   d. Always a bridesmaid.
   e. The complainer.
   f. The exploited.
2. The seven-point guide to achieving assertion on the job.
   a. Point one: Thinking through your job goals.
      (1) Reality job goals.
         (a) To earn a living.
         (b) To make as much money as you can.
         (c) To achieve glory, status, prestige.
         (d) To find reward in terms of your interests and skills.
         (e) To achieve personal growth and a feeling of movement through life.
         (f) To make a social contribution through meaningful work.
      (2) Neurotic job goals.
         (a) The need to be needed.

(b) The need to be liked rather than respected.

(c) The need to master impossible situations.

(d) The need to be a good child, to win approval.

(e) The need to have the world feel sorry for you.

C. Primary Source of Instruction

1. Fensterheim, J., & Baer, J. (1975).

D. Clinician's Narrative

My intention was to complete the material from the previous session and to introduce the students to the new topic of Assertion on the Job.

I spoke with the students about the fear of learning the truth, which underscores some people's preference for staying with their fantasies about themselves rather than testing reality to find out what they are really like. I discussed the fear of retaliation in which one is afraid of being chastised or humiliated or is legitimately afraid of violence from the other person. We also discussed the fear of authority figures and the ways in which we tend to make people more powerful than they really are by projecting power onto them. Again I underscored the healthy alternative of trying to test reality in order to discover if the other person is much less powerful than imagined, or if one has more power than she realized. We discussed why individuals are inclined to attribute more power to the other person than is really there, and I suggested that an individual may be in collusion with the other person so as not to expose the other's true weakness, i.e., as long as one person remains submissive, the other individual will feel dominant. (The fear of authority figures

seemed to be one of the most relevant fears for the students. We will touch on the subject once again when we discuss independence.)

I then introduced the students to the new topic, Assertion on the Job, with the anticipation that they would, with one accord, find the subject relevant. I discussed with them the various unassertive job types hoping they would be able to identify with at least one of the types. I got the most reaction from my description of the "person in the background" (i.e., the individual who does an excellent job but nobody knows it) and "the exploited" (i.e., the individual who smiles sweetly and says "yes" to every request, is overworked, rarely receives a thank-you, and hasn't learned to say "no" to unreasonable requests). The latter unassertive job type, which is also characterized by outbursts of crying and anger on the job, depression or annoyance at home, and finally an impulsive change of jobs, was clearly the one with which students identified most.

I then discussed the first point of the seven-point guide to achieving self-assertion on the job (and ultimately getting what they want from their jobs). The purpose was to provide an opportunity for students to think through their job goals and to encourage students to perceive whether their job goals were realistic or neurotic in nature. I was able to take them through the reality goals during this session and to get their reactions to these. I was particularly concerned that the students realize that I was not suggesting that one goal was better than another, and that I made no value judgments about the goals nor wanted them to. The goals were discussed from the standpoint of their connection with reality. I stressed that this was their essential quality, and, if realistically pursued, the goals

could bring about the possibility of later job satisfaction. We will finish the discussion of point one (neurotic job goals) when we next meet.

E. Researcher's Validation of Instructional Intent and Comments

As the clinician noted in his narrative, he was unable to cover all of the subject matter as planned. He will continue point one, of the seven-point guide to job assertion, during the next session.

The tape reveals that a number of students were openly resistant to group involvement. The clinician called attention to this fact at the outset of the session when he stated, "Are you going to be listening, those of you who are writing? . . . OK . . . I understand we can operate with more than one sense, so that's OK." One factor which may account for the apparent need for some students to withdraw from the group may be related to the timing of this session. In this regard, the session occurred only a few days prior to the time when mid-term grades and student appraisals are distributed. It is a point in time commonly associated with high levels of anxiety and a preoccupation with academic performance. Students may have been using workshop time to get caught up in their coursework. In addition, and as previously noted, resistance may also be linked to the specific approach being utilized in this workshop. An intervention which is heavily grounded in a cognitive approach to behavioral change can require a great deal of work on the part of group members. In this regard, the inexperienced supportive agent employing such an approach may find himself feeling impotent if students are not receptive to the service being delivered, and will

have to recognize that, while the opportunity to learn is available to all students, not all group members will find even the best intentions worthy of consideration, particularly within a program that has not been voluntarily chosen. In this sense, the clinician can only teach to those who want to be taught, interact with those who seek active involvement, communicate to silent members that he is aware of their presence, and continue to do whatever he can to engage all members in group work without placing any single person in a defensive position.

As noted, the unassertive job types topic was of considerable interest to the students. The clinician actively challenged students to act upon any possible unassertive behaviors they may recognize in themselves by commenting, "I would hope that if you are any one or the other of these types, you will realize it and see what you can do about changing it, because they are all dysfunctional." It is of interest that the tapes reveal that many students have felt exploited on the job, particularly in terms of being underpaid. (According to a needs assessment conducted in February 1984, graduates of the Medical Assistant Program also communicate that they are dissatisfied with their salaries in the health-care delivery system.) Perhaps as students try to become more assertive and begin to examine old behavior patterns which have not worked for them in the past, they will begin to negotiate their environment in such a way that the risk of placing themselves in a position conducive to exploitation will be significantly reduced in the future.

SESSION TWELVE: ASSERTION ON THE JOB (Cont'd)

INTRODUCTION TO INDEPENDENCE

A. Objectives

1. To complete the discussion of the seven-point guide to achieving assertion on the job.
2. To introduce the concept of independence.

B. Curriculum Outline

1. The seven-point guide to achieving assertion on the job (Cont'd).
   a. Point Two: The active approach to getting the job that is right for you.
   b. Point Three: Make sure you have the skills to maintain your job.
   c. Point Four: Learn to control general anxiety on the job.
   d. Point Five: Learn to control the specific anxiety you have learned to associate with a specific job task.
   e. Point Six: Master the art of good personal relations on the job.
   f. Point Seven: Negotiate the system.
2. Introduction to the concept of independence.

C. Primary Sources of Instruction

1. Emery, G. (1982).
2. Fensterheim, H., & Baer, J. (1975).

D. Clinician's Narrative

I wanted to finish talking to the students about assertion on the job and then introduce the topic of independence. I accomplished

this end by beginning the session with a presentation of neurotic job goals. These, in contrast with the reality job goals I had talked about during the previous session, were job goals that were unrealistic, exaggerated, and psychologically unhealthy. I talked to them about the need to be needed, the need to be liked rather than respected, the need to be the good child to win approval, et al. The students seemed to be able to relate to some of these, although they were not very verbal (probably because they did not wish to ostensibly associate themselves with something that had previously been labeled by me as neurotic). They did listen closely; however, they didn't respond overtly.

I then continued with the rest of the points of the seven-point guide to getting the most from their jobs. Point two had to do with their taking an active approach to getting the job that is right for them. This included planning their overall strategy, gathering necessary information, finding out where the jobs actually are, mastering the art of performing well at the interview, and making direct, assertive approaches to possible employers. I elaborated on each of these.

Point three was related to making sure that they have the skills to maintain their job once they get it. I talked to them about learning skills that would help them move on to a higher job, if that was their aim, about taking an active orientation to their working environment to make it optimal for themselves (and not to be afraid to ask for the things they needed to do the job well), and about using self-control on bad habits that tend to interfere with work (e.g., chewing gum, doing their nails, talking too long on the telephone, etc.).

Point four had to do with learning to control general anxiety on the job. During the discussion I introduced the students to a practical relaxation exercise: taking deep breaths, holding them, and letting them out slowly as they pictured a calm scene and relaxed their muscles. I demonstrated the exercise and, while I was able to get some of the students to participate, most of them did not take it too seriously and there was a lot of fooling around and giggling.

Point five related to how the students might overcome the anxiety they may have doing a specific job task. When I asked them to name a specific job task that might make them anxious, they almost with one accord said, "taking blood." I therefore talked to them about the technique of systematic desensitization and showed them how to apply the technique to the process of taking blood. They seemed to get the idea and acted as though they found this discussion relevant.

Point six had to do with mastering the art of good personal relations on the job. I talked to the students about the good sense involved in making it easy for people to do what they want them to do. I provided an example of this concept by talking about the things they might keep in mind when asking for a raise. I also advocated speaking up, not only to praise others but to keep others from putting them down. I discussed the importance of defining problem behaviors in job interpersonal relations and why it is vital to deliberately work to change them.

Point seven related to learning to negotiate the system (i.e., having knowledge of the business system in general and their job situation in particular. We talked about keeping their job goals in mind and knowing how to deal with the prejudices they may face

(i.e., being a woman, single parent, divorced, etc.). We also discussed the reality of sexual harrassment and possible ways of dealing with it. Finally, I discussed the healthy aspects of knowing when to quit one's job.

During the remainder of the session, I introduced the students to the concept of independence and to the terminology that I will be using in that connection. I discussed choice points, the four things in the world from a perceptual standpoint (i.e., how we feel, think, act and the rest of the world), and the ACT Formula (i.e., accepting reality, choosing to be independent, taking action). The students seemed eager to get to the topic of independence. I think they will find it most relevant.

E. Researcher's Validation of Instructional Intent and Comments

The tapes confirm that the clinician covered all of the points outlined in his narrative.

In addition to the issues planned for the session, other features of the encounter are worthy of consideration. To begin, the students were unusually disruptive, particularly at the beginning of the session. As the clinician progressed through his material, the noise level and abundant outbursts of laughter made it very difficult for him to present the subject matter. It appears once again that the obstreperous behavior evinced by students is episodic and related both to specific categories of subject matter, as well as tensions that seem to be accelerating in the Medical Assistant Program. In this regard, it may not be coincidental that students would be highly aroused one day prior to the distribution of mid-term grades, and on

a day when the topic of sexual harrassment was to be discussed. In order to ameliorate the learning climate, the clinician made several attempts to quiet down the group by interrupting what he was saying, waiting a few moments for the noise to subside, and continuing his discussion. This strategy worked initially; however, it finally became necessary to confront a student who seemed to be competing with the clinician for the group's attention (using jokes and laughter as the mechanism for diversion). The clinician stated, "Do you understand that you make it difficult for me?" The student replied, "I know. I'm sorry." He went on to say, "I can take some of that, but not as much as I'm getting. OK? I know this isn't a class, and we need interaction, but . . ." The students seemed to settle down after the confrontation, but only until the topic of sexual harrassment was discussed toward the end of the hour. During that discussion, the students once again began to giggle and would not personalize the material. The clinician could elicit little response from students when he asked them if they could "relate to sexual harrassment"; however, students became responsive to the question, "Will you be able to maintain your integrity when authority figures try to take advantage of you?" In this regard, the clinician related the sexual harrassment issue to a fear which had been acknowledged during a previous session by many group members (i.e., the fear of authority figures). The integration of the two topics by the clinician seemed to make the material more relevant for the students and, at the same time, appeared to move them from the here-and-now to the there-and-then, a place where students apparently feel less threatened.

There is evidence that another interesting group dynamic was emerging. While caution must be exercised in inferring a causal relationship, there appears to be some indication that a number of students were displaying attention-getting behaviors as a function of their attraction for the person of the clinician. In this regard, a form of subtle seduction seemed to be surfacing that manifested itself in overt expressive behaviors with sexual underpinnings, as well as more covert modes of communication (i.e., double entendres, slips of the tongue). A plausible explanation is that the subtle, as well as explicit, messages were a function of a transference reaction. It is important that group leaders recognize transference as a universal characteristic of human beings, and understand that the phenomenon not only surfaces in individual psychotherapy but in group work as well. Thus, it is not unusual for highly charged emotions ranging from open hostility to genuine expressions of love to be cathected onto the therapist. Regardless of the particular psychotherapeutic persuasion espoused by the clinician (i.e., Psychoanalytic, Rational-Emotive, Gestalt, etc.), the transference process can pose potential threats to the group in general and to the individual in particular if the clinician's countertransference behaviors are not resolved, or if the transference process is interrupting group work. While the clinician makes no mention, either on the tape or in his notes that transference may have been taking place, this researcher believes that occurrences of resistant behavior, attention-seeking behavior and symbolically mediated displacement were intricately tied to the transference phenomenon.

SESSION THIRTEEN: INDEPENDENCE (Cont'd)

A. Objective

1. To introduce students to the first step of the ACT Formula: Accepting Reality.

B. Curriculum Outline

1. Barriers to acceptance.
   a. Nonawareness.
   b. Disbelief.
   c. Anger.
   d. Depression.
   e. Anxiety.
2. Acceptance and self-awareness guidelines.
   a. Own your own actions.
   b. Own your own feelings.
   c. Own your own success.
   d. Approach what you fear.
   e. Watch your visual images.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I wanted to set the stage for this presentation by reviewing the last part of session twelve. I first talked to the students about the four aspects of our perceptual reality: how we think, feel, act, and the rest of the world. I explained to the students that we can do a lot about controlling the first three, but very little about controlling the fourth.

I then talked to them about the elements of the ACT formula which, if followed, leads to increased independence: (a) Accepting reality, (b) Choosing to be independent, and (c) Taking action. I first wanted them to think about the detours that they tend to go through before they reach acceptance. There were five of them I wanted to mention. In each case, I named the detour, then characterized it with a statement (so that they might better identify with it) and then discussed the distortion that keeps them dependent.

The first detour I discussed was nonawareness, which was characterized by the statement, "I don't want to know." The distortion in this stage of nonacceptance revolves around the tendency to gloss over everyday problems that come up; they are not dealt with until it's too late or one refuses to admit her mistakes. As a result one never learns to correct her mistakes.

Disbelief was characterized by the statement, "I don't believe it." In this case, one believes it intellectually, but doesn't accept it emotionally. The distortion revolves around how one feels the world "should" be, and the gap between how one sees the world and how one feels it should be, causes one pain.

Anger was the next detour to be discussed. This stage of nonacceptance was characterized by the statement, "Whose fault was it?" In this detour one plays the blame game, and the distortion has to do with the belief that one can change the fourth aspect of reality - the rest of the world - by stamping one's foot and willing it.

The next detour discussed was depression, which was characterized by, "What about me, what have I lost?" The distortion

is that in addition to focusing on one's losses, one stays depressed by acting on the idea that one is a loser, and the only option for a loser is to give up. Giving up keeps one stuck in this stage.

Anxiety was characterized by the statement, "What will happen to me?" The distortion that keeps one dependent revolves around not being able to accept the possibility that something bad could happen to one in the future. It is a demand for one's guaranteed safety in the future; by not accepting that life can't offer such guarantees, one becomes stuck in this stage.

I explained to the students that acceptance starts with awareness. Once they become aware of their thoughts, feelings, and actions, they can start to make more independent choices. I told them that they could increase their level of self-awareness by putting certain guidelines into practice. I named the guideline, characterized it, elaborated upon it, and then entertained feedback from the group. I received more response to the guidelines than I did to the topic of detours.

Own your own actions: The thrust here was to get the students to see themselves as making choices (i.e., even if they follow someone else's demands, they are the ones doing the following).

Own your own feelings: The students were told that they were not owning their own feelings when they made the statement, "My _____ made me angry by coming home late." I explained that they needed to start putting their feelings in the first person (e.g., I feel angry when my _____ comes home late).

Own your own success: I emphasized the tendency to attribute their successes to others, or to change, and by so doing to block out of their awareness the role they played in the success.

Approach what you fear: I talked to the students about the positive aspect of confronting what they are afraid of. I explained that while they may be uncomfortable, they can gain valuable information about themselves by confronting what they are afraid of. I shared with them that fear, if nothing else, wakes them up.

E. Researcher's Validation of Instructional Intent and Comments

The taped recording of the session reveals that the clinician followed the curriculum outline as planned; however, he did not cover the topic entitled "Watch your visual images" which related to being alert to fantasies that make a person fearful. While the narrative does not mention why the subject was not included in the workshop session, it is speculated that there was not enough time left as a result of the amount of discussion that was generated in other areas.

The clinician judiciously used the curriculum format as a springboard for discussing related topics that were of concern to the students. As the narrative suggests, the students were not verbally responsive during the discussion about distortions.

The students seemed to have a great deal of difficulty comprehending how they might be caring and, at the same time, honest with their feelings and needs. They were particularly responsive to the related discussion about anger, and many disclosed that they found it very difficult to get angry. The clinician spoke with them

about the ramifications of denying the reality of their anger, and suggested that it is very difficult for some people to perceive themselves (or allow others to perceive them) as angry, even when anger is the appropriate response to a situation. This topic was discussed early in the workshop, during session five, at which time a significant number of students revealed unhealthy ways of dealing with anger (i.e., by denying the reality of the existence of anger, and/or by displacement). It is not surprising that the topic of anger would generate an animated discussion. In terms of this discussion, as well as its implications for personnel who provide supportive services to adult women, the expression of anger by females in our culture is not a prized behavior. Because it is discouraged during the socialization process, many women have learned to suppress intense feelings of anger. As Henley & Freeman (1984) point out, as a result of the suppression of anger, women become "intropunitive: and punish themselves for their own anger rather than expressing it outwardly" (p. 472). It appears that the students more clearly identify with submissive expression than active expression when dealing with their anger (e.g., During an earlier session, many students could relate to the clinician's characterization of the assertive problem type who, when someone steps on her foot, is likely to say, "I'm sorry.").

During the session, most of the disclosures were communicated in the first person, and many reflected the difficulty these women were having comprehending that it's OK to think of themselves first. Some shared that they feel a great sense of guilt when they speak openly about their feelings. To these comments the clinician replied,

"Guilt is the result of the inability to discriminate between that for which you are, and that for which you are not, responsible." He went on to explain that "it is very difficult for an individual to walk away from a person who looks very needy, particularly if you are a caring person or a person who needs to be needed."

In addition, the students had considerable difficulty accepting the tenets offered by the clinician relative to owning one's responsibilities. It is interesting that when the clinician stated, "No one can make you do anything, feel anything, or think anything. It is too easy to talk about other people making you do this, or making you do that," students began to argue their case, offering all sorts of rationalizations for why the notion is fallible (e.g., the environment plays a significant role in why we behave the way we do). The clinician apparently perceived the difficulty students were having with the concept of owning responsibility, and presented some suggestions which might help them, at least behaviorally, confront and accept their anger in ways that would be sensitive and caring toward the other person. Thus, he explained why "I" messages are effective in communicating feelings of anger (i.e., "You can look at whatever it is that is making you angry as being something that is 'out there,' that the two of you can look at together, as opposed to looking at it as something 'in here,' that is, in the other person."). The clinician shared his own perceptions of the two essential responsibilities that individuals have when communicating how they feel: (a) to be emotionally honest with the other person, and (b) to be caring and sensitive in the way in which a feeling is communicated. Beyond this, he explained, it becomes

the other person's responsibility to choose how he or she is going to react to the communication.

Taking a more critical look at the students' obvious resistance to the possibility that there is a mediating ego (i.e., that the organism can be an active mediator in stimulus-response connections), there are identifiable antecedents which may be responsible for the students' inability to accept the basic assumptions underlying individual freedom and choice. In this regard, to "own" responsibility for one's actions, feelings, and thoughts requires that people activate their potential as free-will agents. Hence, to acknowledge and accept this "choice" element requires that individuals adopt assertive and independent behavioral patterns. Conversely, if individuals do not take responsibility for their actions, feelings, and thoughts, they are likely going to feel as though they are passive recipients of externally imposed controls. In its extreme form, the behavioral antecedents which may be fundamental to the phenomenon of resistance exhibited during this session bear some resemblance to a learned helplessness state. According to Seligman (1975), learned helplessness "has its roots in the belief that valued outcomes are uncontrollable" (p. 105).

Finally, it is rather striking, and probably not coincidental, that the issues which have generated the most fervent student-centered discussion revolve around four central categories: guilt, self-esteem, anger turned inward, and loss of control. These categories represent four of the five factors which Hammer (1972) asserts are the psychodynamic causes of depression.

SESSION FOURTEEN: INDEPENDENCE (Cont'd)

A. Objective

1. To continue the discussion of the first step of the ACT formula: Accepting reality.

B. Curriculum Outline

1. Acceptance and self-awareness guidelines (Cont'd).
   a. Think through unpleasant experiences.
   b. Fully experience your feelings.
   c. Increase your range of emotional experiences.
   d. Keep your mind open.
   e. Stop setting up self-fulfilling prophecies.
   f. Seek out and listen to feedback from others.
   g. Question all your present beliefs.
   h. Develop new friends and associates.
   i. Seek out new experiences.
   j. Take an active instead of a reactive approach to life.
   k. Be more honest with others.
   l. Be honest with yourself.
   m. Question your inconsistencies.
   n. Deprive yourself.
   o. Keep looking.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I intended to finish my presentation of guidelines to increase self-awareness. I was not able to complete the discussion.

I started the session by talking to the students about how they could increase their self-awareness by forcing themselves to think through painful memories - not that they should engage in second-guessing or judging themselves, but that they should engage in thoughtful self-examination (e.g., "Exactly why did I choose to do what I did? I'll reconstruct it in my mind and see what happened.").

I then talked to them about fully experiencing their feelings. I gave them the example of finding themselves with a group of people and feeling uncomfortable. They then had three choices: (a) physically leave, (b) tense up and psychologically escape by distracting themselves, or (c) stay and feel the way they do and say to themselves, "Let me experience this feeling." We talked about the latter alternative as the healthy choice which leads to greater self-awareness.

Next, I talked to the students about a related subject: increasing their range of emotional experiences. I rattled off a long list of emotions and suggested that they take some time out to try to perceive what these emotions feel like. I talked to them about how they could become congruent where their feelings were concerned by becoming more aware of a feeling at its inception (i.e., the physiological stirring), labeling it according to the context in which it is experienced, and then communicating it accurately.

We then talked about the importance of keeping their minds open. I talked about the psychological implications of being "nearsighted" (e.g., "taking the nickel now instead of the quarter later"), and how they needed to learn how to tolerate ambiguity and uncertainty before reaching conclusions; of being "farsighted" (e.g., "thinking it will

take care of itself in the long run") and how they needed to check into it now. I also talked to them about having "tunnel vision" (e.g., "their job is so important that they don't have time to think about their family"), and how they needed to expand their interests, learn to tolerate blind spots and tell themselves to keep an open mind about this.

Next we talked about the inclination to set up self-fulfilling prophecies. I explained that they have a notion about themselves (e.g., "I'm helpless") that they automatically act out (e.g., "Only my husband can help me out of this situation"). I wanted them to also think about times they made a prediction (e.g., "They won't like me") and then worked to make this a reality.

I also talked to the students about seeking out and listening to feedback from others; when they found themselves starting to tune out, they should consciously force themselves to stay awake (so they might learn something new about themselves that they could use later).

I asked the students to question all their present beliefs, and suggested that they ask themselves, "What don't I want to know that would contradict my present beliefs, and why don't I want to know it?" Then I gave them a quote: "The weakness of a soul is proportionate to the number of truths that must be kept from it," and we talked about its meaning (i.e., that there is strength in allowing ourselves to be more open to questioning our beliefs).

Then, I talked to them about their tendency to associate with the same kinds of people and thus inhibit themselves from learning new things about themselves. I explained that this could be remedied

if they decided to seek out people who didn't share their world view and related to them.

I also talked to the students about the importance of their becoming more of an actor than a reactor (more of an origin than a pawn). I talked to them about emotional liability and how that conversely related to their degree of control of their lives. I talked to them about that "trapped feeling," and how they needed to find at least one thing that they could gain control of and to deal with that feeling.

Finally, I talked to the students about the importance of being emotionally honest with others, and how their honesty with others could spark others into being more honest with them. I pointed out that often when we say that we are protecting others from ourselves by being less than honest with them, we may in fact be protecting ourselves from their reactions to our honesty, which we are not sure we can handle.

These topics facilitated a great deal of discussion and it was obvious from their responses that they found the issues relevant.

E. Researcher's Validation of Instructional Intent and Comments

The clinician completed the discussion of the guidelines to acceptance and self-awareness inclusive of the topic "Be honest with yourself." He was unable to cover the entire format as planned.

The tape reveals that while a large group of students remains very responsive, a segment of the total group continues to engage in disruptive idle chatter which indicates the possibility that the nonparticipatory population has become highly crystallized. Further, the tapes suggest that some students are extremely

communicative during the discussions, while some remain moderately expressive. Others (beyond those who refuse to commit themselves at all to the group process) listen attentively, but do not participate in group discussions. As alluded to earlier in this researcher's comments, the involuntary nature of the group intervention may have a bearing on the level of commitment exhibited by participants. As Corey & Corey (1977) posit, "Counseling involuntary clients presents a number of problems, for, although clients can be required to attend sessions, they cannot be forced to work." The authors add, "If the motivation for change is lacking, a group counselor may experience great frustration" (p. 91). An analysis of his voice quality, as well as the content of the clinician's communication, reveals that he has become increasingly more frustrated when the noise level has become so great that it interferes with group work (e.g., He is frequently heard asking students to listen to other students, and often says, "Please!" and "Ssh!" He does not, however, appear unsettled about the nonparticipatory behavior of certain students.).

During this session, the clinician discussed the notion of congruence (see Rogers, 1961). It is of interest that when he stated that the "incongruent" person feels something inside that is different from that which he is communicating outwardly," the subject of anger once again surfaced. In this regard, a student commented that she feels incongruent with respect to her feelings of anger and her expression of those feelings of anger. The clinician offered some insights into her behavior and suggested the possibility that people in our culture are taught to be incongruent. He also discussed how reaction formation (i.e., "the defense mechanism which

we use to reveal ourselves outwardly in one way when inwardly we are quite the opposite") prevents individuals from congruently accepting and experiencing emotions.

During the discussion of the implications of being nearsighted, farsighted, and tunnel visioned, the clinician aptly pointed out that there are both positive and negative aspects to each concept. By way of illustration, in his discussion of farsightedness (i.e., checking into things now), he noted, "Sometimes it is better to get your mail, but wait until tomorrow if you think it is going to be aversive for you to open it today." This example of "healthy avoidance" tended to reduce the probability that students would perceive the guidelines in either/or terms. Examples like these are particularly meaningful for women whose personalities are characterized by a form of "cognitive constriction." These women tend to lack flexibility of thought and require a great deal of structure. They also respond well to external direction, but are limited in their own uniqueness of thought. For these women, it is important that they begin to challenge "absolutism" and begin to take stock of the "gray areas" which are representative of reality. In this sense, an instructional mode which does not underscore either/or propositions may reduce the probability that these women will become even further polarized.

The clinician once again challenged the students to consider how much they might be contributing to their own self-deprecating behaviors through "negative self-talk." He urged them to get in touch with the "opposite side" of themselves by talking to themselves differently. He stressed that as they begin to think differently,

and subsequently "do" differently, their self-esteem will be affected accordingly.

It is particularly noteworthy that the students who are disclosing tend to be more spontaneous in their communications, and seem to be less threatened and anxious about their disclosures. They are less prone to giggling, more serious about the subject matter, and they have also become more articulate in their verbalizations. It is interesting that students now rarely talk about what others seem to be doing and feeling, but rather about how they themselves are feeling, what they are thinking, and what they are experiencing. This "movement" through change is reminiscent of the stages commonly associated with non-directive psychotherapy in which individuals are known to progress: (a) from an unwillingness to communicate self, preferring rather to communicate about external events, (b) to a midpoint on the continuum at which point individuals begin to talk about themselves as objects, (c) to a point at which they begin to "own" themselves and their feelings and experiencing and, thus, begin to communicate themselves in that way (Meador & Rogers, 1973). This researcher would suggest that students are exhibiting behaviors which are associated with varying points on the continuum; however, a number of these adult female students seem to be eliciting behaviors which indicate they have passed beyond the midpoint.

SESSION FIFTEEN: INDEPENDENCE (Cont'd)

A. Objective

1. To continue the discussion of the first step of the ACT formula: Accepting reality.

B. Curriculum Outline

1. Correcting Distortions.

   a. Run real world experiments.

   b. Keep a written record.

   c. Straighten out twisted thinking.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I wanted to finish talking to the students about the guidelines to increase self-awareness which I was unable to complete during the previous session. I spoke to them about being honest with themselves, which included not overstating their faults (which is the mechanism people use to keep from admitting their real problem). I also talked about the notion of questioning inconsistencies which includes asking themselves questions like, "If I don't want to go, why am I afraid to say so when I'm asked? What consequences am I afraid of?" I discussed the guideline that relates to depriving themselves, which involves being so comfortable that one can block out self-awareness (e.g., sleeping when they are not tired, and eating when they are not hungry keeps one unaware).

Finally, to wrap up our discussion of self-awareness, I talked to the students about self-awareness being a continuing process without end. When they say, "I finally know myself," they can assume they just lost their awareness. Taking stock of themselves is one of the best habits they can develop.

Next, I wanted to share with them ways in which they could go about correcting their distorted thoughts and beliefs. I suggested that they could use two general methods: an experimental method and a written method. I explained that the first way to correct their distorted thoughts is to run behavioral experiments. The thoughts that keep them dependent and away from reality are often predictions like, "I can't go there on my own," "I won't be able to enjoy myself if I'm alone," "They will make me feel uncomfortable," "I'll mess it up," "If I don't ask for their help, I won't know what to do." In this connection I talked to the students about the "If - Then Syndrome" that manifests itself in their thinking and believing a priori that if they do something then something that they are afraid of is going to happen. I talked to them about their tendency to let their fantasies control them and how they needed to test reality and take chances and discover that either what they thought would happen didn't, or if it did, they could handle it.

I wanted them to try running their behavioral experiments especially when they are afraid. I explained that there were four steps to take: (a) Spell out what their prediction is (e.g., "I won't be able to . . . ."), (b) Devise a way to test their prediction, (c) Develop a way to measure the outcome, and (d) Evaluate results and devise new experiments if needed.

If the students wanted to keep a written record to help them correct their distorted thoughts and beliefs (which contribute to their dependency), I gave them the information and motivation they needed. Basically, I talked to them about keeping track of the two parts of themselves, the part that was a legacy from their childhood (which they could label "Little Suzy") and the part that was the mature self (Susan). It was suggested that especially when they got into dependency-producing situations they could ask themselves what these two parts of themselves were saying. I gave them suggestions to correct their distorted ideas and strengthen their mature part. For example, they could ask themselves, "What exactly do I find unacceptable?" By questioning what they don't want to accept, they will be able to pinpoint which of the beliefs they need to challenge the most.

I especially wanted them to see the necessity of testing reality rather then denying it or dodging it. I think I got this point across in different ways during the session. Their reactions and responses convinced me of this.

Finally, I talked to them about five common thinking errors that I thought they could relate to. I labeled each, characterized each, and got feedback from them about each. They were: (a) personalizing (i.e., believing they are the center of everyone's attention), (b) overgeneralizing (i.e., believing that if it is true in one case, it applies to any case that is even slightly similar), (c) either/or thinking (i.e., believing everything is either one extreme or another, black or white, right or wrong), (c) jumping to conclusions (i.e., believing if it is true in the past, it is always going to be true,

or if it appears true, it must be true), and (e) false comparisons (i.e., believing they are just like someone else, and if the someone else has done well, then that means you have done badly). (The students had trouble understanding this concept at first; however, after I explained it with examples, they could relate to it.)

Of all the common thinking errors, the students responded to the either/or thinking error the most.

E. Researcher's Validation of Instructional Intent and Comments

The tape conforms to the topics covered as indicated in the clinician's narrative.

At the beginning of the session, one of the students presented a rather graphic description of a telephone call her stepmother received from an anonymous caller that morning. The clinician listened attentively to the disclosure that was intended for him and responded several times by saying, "That's terrible." His reactions to the pictorial did not, however, encourage more than a passing account of the incident. It is clear that having focused on the particular problem of the student would have been at the expense of group work. The clinician listened; however, at the first opportunity, he moved into the subject matter outlined for the day. It is of considerable importance that providers of cognitive group interventions recognize that they will likely encounter the individual who is experiencing psychological conflict. As the forementioned exchange illustrates, the interaction between the clinician and counselee will be quite different in a task and/or process-oriented group intervention in comparison to individual

therapy or group therapeutic approaches which attempt to alleviate specific symptoms or disorders.

This researcher's earlier perceptions of the clinician's frustrations relative to disruptive behavior were corroborated during this session. At the commencement of the discussion, the clinician stated, "This is the fifteenth session, which means we have only six or seven more of these and then we are through. So, what I want to ask of you is a little more cooperation than I have been getting of late. I'm talking about the extraneous noise . . . a lot of talking that I don't think has anything to do with what we're talking about. I'm asking that you keep that down to a minimum, OK? I think it's distracting, also, to the people who really want to get involved and interact." He went on to clarify that he didn't want his statement to be a deterrent to interaction, and that he only meant to "put an end to the extra stuff which seems to be getting in the way and seems to be more and more each time." He also asked students to appear for class on time. Following his appeal, the clinician and students were able to interact in the absence of noise.

During the session, the principles of reality testing were emphasized. It is rather clear that the clinician's discussion of real world experiments and written records (for correcting distorted thoughts and beliefs) presented the students with an opportunity to gain a feeling of mastery and control over their environment. It will be recalled from an earlier session that one of the primary dysfunctional states which seems to characterize many of these women stems from the feeling that they are unable to control events in their lives (i.e., that events are externally imposed upon

them). The behavior experiment and written record methods which the clinician urged students to follow provided them with the opportunity to: (a) alter their propensity for the denial of reality, (b) test the reality of negative self-talk and erroneous belief systems, (c) gain some control over their thoughts and beliefs, and (d) realize there may be a "self" (mediating ego) which plays a significant role in manipulating the environment and controlling how they think, feel and act.

What is also rather striking is the validation of an earlier perception by this researcher that many of these women tend to have a predilection for either/or thinking. In this regard, the clinician spoke at length about rigidity, a need for structure and the inclination for some people to "make things too simple." He stated, "When you dichotomize this life and have only two categories for it, what do you do with all the things in between? Either you ignore them or you deal with them (and very likely relegate them to one end or the other)." In this way, he explained, students would not be dealing with reality, because "most of reality lies in the gray area."

It is this researcher's impression that this was an efficacious session for the students. Many were very responsive as they were offered (perhaps for the first time) an opportunity to examine more closely those feelings and thoughts which heretofore have been consciously or unconsciously classified as "untouchable." In this regard, the clinician provided substantial consciousness-raising cognitions, as well as sufficient methodological tools, to help students begin to rationally, directly, and freshly examine reality.

By so doing, the students had an opportunity to: (a) challenge their own stereotypic thinking, (b) modify cognitive rigidity, (c) stir up old maladaptive behavioral patterns, and (d) acknowledge and accept the realities of their phenomenological worlds.

SESSION SIXTEEN: INDEPENDENCE (Cont'd)

A. Objectives

1. To conclude the discussion of the first step of the ACT formula.
2. To introduce students to the second step of the ACT formula: Choosing to be independent.

B. Curriculum Outline

1. Correcting distortions (Cont'd).
   a. Seek objectivity.
   b. Access probability.
   c. Consider the worst possibility.
   d. Rescue factors.
2. Choosing to be independent.
   a. Life's two choices: To be dependent or to be independent.
   b. The importance of choice.
   c. Becoming aware of your choices.
   d. Choice and feelings.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I wanted to finish up the discussion revolving around the subject of accepting reality and then move on to step two of the ACT formula which has to do with choosing to be independent.

I started this session by talking about the need to seek objectivity when looking at their situation. I explained that the students might do this by looking at their situation the way in which

another person might look at it. I also urged the students to realistically ask themselves what the probabilities are in the situation that confronts them. I wanted them to ask themselves whether they weren't sometimes confusing low-probability events with those of high-probability, and making a slight possibility into a certainty.

Next, I wanted the students to try thinking through the worst possible scenario, to construct a catastrophe scale that goes from 0 (nothing bad happening to them) to 99 (the worst possible event), to put their worst outcome on that scale. I wanted them to push beyond just imagining the feared situation; I wanted them to question the consequences. The students balked considerably about doing this. They brought up arguments and rationalizations that ranged from what one might call superstitious behavior (i.e., if they thought about it ahead of time it would be more likely to happen) to cogent reasons (i.e., not wanting to get themselves unduly stirred up before the fact, not wanting to borrow trouble before trouble comes lest they make themselves overly fearful even before anything happens). It was difficult to get this point across. Part of this, of course, had to do with our resistance to think about things that we don't want to think about and the fact that denial and avoidance are favorite defenses for many of us.

I had intended, at this point, to talk to them about rescue factors (i.e., factors that they might use to help them face reality). I thought better of it for two reasons: (a) I wanted to get on to step two of the ACT formula, and (b) I didn't want to offer the students the alternative of other help (which might inadvertently

encourage them to think in terms of others, rather than themselves, when facing reality). I wanted them to become more responsible in this regard and not look to be rescued.

We then moved to step two of the ACT formula: Choice. For an introduction, I wanted to impress on them that they always had choices. I felt that this would be a hard concept for them to understand and accept. I assumed that they would be more accustomed to thinking in terms of "I have to" or "I should" rather than "I choose to." I was right. They really perked up and became interested when I made the following statements, "When you believe you have choice in your life, you suffer less distress," "When you say you have 'no choice' you really mean that you don't like your options." The students had no trouble relating to my comments about how telling themselves "I should feel . . ." is counterproductive. I impressed upon them that self-commands run against one of the most basic laws of human behavior: You don't want to do what you are told you have to do.

The discussion has helped students begin to perceive themselves as choosing agents and as having far more to say about how they think, feel and act then they imagined. It has captured their imagination and has stirred up desires to change and take more control of their own lives.

E. Researcher's Validation of Instructional Intent and Comments

The clinician covered the topics as outlined in his narrative. Beyond that which is reported, the taped recording reveals additional information which has shed some light on the clinician's impression of the psychological conflicts encountered by many of these women.

As noted in the clinician's narrative, during his discussion of the "catastrophe scale" the students became highly resistant. More specifically, as the clinician was attempting to emphasize the importance of a pictorial cognition that might help students better prepare for a feared event, he stated, "Try to picture in your mind that you are dealing with the worst possible scenario. Doesn't it stand to reason that you will have more confidence if you go in and deal with what might happen? It's a way of desensitizing yourself to that which you fear." The students were quick to deny, deflect, and avoid the rationality of this type of cognitive role rehearsal and responded with statements like, "Why keep yourself awake dreading something you have no control over?"; "Why fabricate that you're happy when you're not?"; "Why don't you have a more positive attitude?"; "Why put yourself under so much unnecessary stress?"; "I don't ever think that anything will ever be that bad." To these comments the clinician responded: (a) that individuals do have control over most events in their lives, and he gave an example of the control that could be exerted in the particular example provided by the student making the remark, (b) that he was not trying to get students to be "happy," but rather to face the fact that they can take responsibility for the way they think, act, and feel, (c) "If you're hearing 'negative' than I need to know that because that is not what I am trying to communicate . . . I'm talking about techniques you can use to help yourself get ready for something that you are afraid you may not be able to handle," (d) "Are you saying that if you don't think about it, then you won't get yourself all shook up?" Judging from the ensuing discussion, it was relatively clear that students

could not tolerate the thought that they are self-determined by the meanings they give to situations. The students' rebuttals strengthened this researcher's earlier assertion that many of these women present themselves as passive recipients of an externally imposed environment. The clinician tenaciously focused on one of the central precepts of Rational-Emotive Therapy: if a fearful event has occurred, or is about to occur, if an individual disputes irrational and magical beliefs associated with that event, using the principles of logico-empirical thinking, disturbing ideas will be eliminated. As the clinician pressed on in his attempts to help students more clearly understand that they often are the creators of their own emotional consequences, the students continued vehemently to refute the suggestion.

This researcher believes the clinician was judicious in his decision not to discuss "rescue factors." The topic is somewhat paradoxical to the topic of independence (i.e., rescue factors include asking for outside help) and the topic may have fostered a perceptual set of dependency.

As the clinician reported in his narrative, the students were very responsive to the notion of "choice." His parenthetical anecdotes regarding the relationship between "have to," "should," and "I freely choose to" were particularly profound. While there were copious "Yeh, but . . ." responses, students were very attentive and presented many personal insights that demonstrated they comprehended his message. In addition, the clinician also provided disclosures which signaled that he could identify with the conflicts which students face. He did not commiserate with the students, nor did he patronize

them; he merely let them know that he understood by describing his perceptions of their dilemma and letting them know that there was something they could do about it. In this regard, he said, "I think a lot of your feelings (of having people impose on you and impinge on you and order you and command you and control you) have to do with the fact that you think in terms of 'should' and 'have to' instead of 'choose to.' The whole thing with this program that you are in . . . all of this homework, and all of these tests and all of these things you see that you 'have to' do . . . you can see that the majority (let's not absolutize them) of those things are things you are choosing to do because they are means to an end for you. I see in your nonverbal behaviors the fact that some of you are needing to remind yourselves on a daily basis that you are choosing to do this." The clinician urged the students to remind themselves continuously that they are capable of choice options. The clinician's disclosures, which were both <u>about</u> the students as well as <u>for</u> them, provided them with truths about themselves regarding the ways in which they deal with reality. The students listened silently as the clinician presented his impressions; when he had finished, it was evident from the responses of the students that he had provided an accurate account.

SESSION SEVENTEEN: INDEPENDENCE (Cont'd)

A. Objectives

1. To conclude the discussion of the second step of the ACT formula: Choosing to be independent.
2. To introduce students to the third step of the ACT formula: Taking action.

B. Curriculum Outline

1. Choosing to be independent (Cont'd).
   a. The relationship between freedom and independence.
   b. Responsibility versus accountability.
   c. Plan A/Plan B strategy.
      (1) Plan A/Plan B guidelines.
   d. Critical choice strategy.
2. Taking action.
   a. I wish I may, I wish I might.
   b. The importance of action.
   c. Developing your independence skills.
      (1) Repetition.
         (a) Key phrases.
         (b) Different situations.
         (c) Look for cognitive clicks.
         (d) Make the repetition interesting.
      (2) Areas of meaning.
      (3) First rung first.
      (4) Step-by-step.
      (5) Initiating technique.

(6) Be your own teacher.

(7) Relating to other people.

3. Take home exercise: Physical Independence Inventory (see Appendix D).

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

This session was conducted under considerable duress. I had a bad cold which affected my voice. I asked the group to bear with me and be extra attentive, but, predictably, only the ones who were usually responsive cooperated.

I intended to finish up our discussion of the second step of the ACT formula, choosing to be independent. I talked to the students about the relationship between freedom and independence and "X" number of choices the individual has to make (i.e., the more choices one is free to make, the more one owns one's own life). I also talked to them about the concept of accountability as it relates to choice: they can choose to be accountable to others or choose not to be; however, if they refuse to buy into any accounts at all (i.e., not make any commitments to anyone), they might end up lonely and isolated.

We then talked about Plan A/Plan B strategy. I shared with the students the steps to take once they had reached a critical choice point (i.e., once they had become aware of the thought and feeling that some action needed to be taken). I explained to them that they could choose Plan A (the dependent way) or Plan B (the

independent way). I asked them to write Plan A in the most dependent way possible and think the reverse when they wrote Plan B.

I explained that when they came to a critical choice point, the first step was to accept that they are the ones who are choosing to be dependent or independent and the second step was to do the opposite of what they felt like doing. I gave them examples of what I meant, such as: when their instincts told them to flee, they needed to stay; when they wanted to protect themselves, they needed to make themselves more vulnerable; if they wanted others to do something for them, they needed to do it for themselves. I gave them a saying to remember in this regard: "Get back on track; take the opposite tack." I felt the phrase would be something they might use when they thought: "This will go on forever," "I can't stand it," "I'm going to go crazy," or "I'm going to lose control."

This idea about doing the opposite of what they feel like doing was hard for them to accept. They could understand what I was saying, but they resisted seeing themselves doing it. Rationalizations and excuses started popping up all over. Their resistance had to do with their natural inclination to avoid discomfort. The dependent way for most of them appeared to be related to their "instinctive" way, the more comfortable way. I spoke to them about the unhealthy aspects of making "comfort" the criterion for choosing and "discomfort" the criterion for avoiding.

I also talked to the students about the importance of taking action and how this relates to the strengthening of their beliefs (i.e., if they believe they're helpless and then act helpless, they

will believe all the more that they are, in fact, helpless). They needed to act differently so that they might begin to think and believe differently. Most importantly, they needed to perceive themselves initiating behaviors; therefore, I gave them some suggestions they could use.

E. Researcher's Validation of Instructional Intent and Comments

The tape reveals that the clinician completed all of the topics noted in the curriculum outline; however, because of his illness, his voice became very weak toward the end of the session and he was unable to complete the final two topics (i.e., "Be your own teacher" and "Relating to other people").

The clinician provided an in-depth discussion of the second step of the ACT formula. In addition to the curriculum planned for the session, he provided a number of insights which gave students the opportunity to examine how rational self-talk can be therapeutic and can eventuate in favorable outcome behaviors. He also briefly discussed Social-Exchange Theory (Thibaut & Kelley, 1959), and suggested that if costs consistently exceed the rewards in a relationship, then students may have to think about getting out of the relationship.

It is of interest to this researcher that although this is the seventeenth session, the students continue to look to the clinician for instant remedies for their psychological conflicts. By way of illustration, one student asked, "Do you have any pointers on how to choose to become accountable again after you have been hurt?" In responding to this indirect question, the clinician explained to the entire group that people "have to be willing to

take a chance without any guarantees of how things are going to turn out." He noted that individuals must tell themselves, "Just because it was that way before, doesn't mean it's going to be that way again." He also expanded upon the student's question by adding, "Anything worthwhile that you want to relate to involves at least an element of hurt." At no time did the clinician propose that there was an easy answer to the question; rather he suggested that issues of this nature cannot be envisioned in either/or terms. He did, however, impress upon students that how they feel will largely determine how they will act when they begin to become accountable for their behaviors.

As his narrative suggests, the clinician encountered considerable resistance as soon as he recommended that students begin doing the opposite of that which they feel like doing. The students were not argumentative; however, it was clear that they did not plan to "Get back on track by taking the opposite tack." While critical choice points can create the opportunity for a heightened potential, as Emery (1982) purports, critical choice moments can be times of serious crisis which may require not only a critical change in perspective, but an increased vulnerability, as well. It appears that students sensed the threat that the critical choice strategy would present for them and reacted accordingly. In addition, while the clinician may be accurate in his impression that much of the resistance exhibited by these students had to do with "their natural inclination to avoid discomfort," the possibility also exists that students openly refuted the concept on the grounds that having accepted it would have been perceived as an admission of guilt

(i.e., indicating interest in the strategy might have communicated to self and others that they have a dependency problem). Any suggestion in the past that students may be experiencing a behavioral deficit has met with resistance. It will be recalled that students were very defensive about having been "singled out" for this workshop and perceived by personnel as having problems. In this regard, it appears that many students prefer to envision themselves as people who do not possess dysfunctional behaviors, and communicate covertly (and often overtly) the message, "This doesn't apply to me, so why should I do it?" Hence, many of the students continue to avoid the possibility that they have dependency needs, and become defensive about being urged to engage in strategies which may help them gain a sense of control over their lives. In this sense, the clinician's remarks regarding the students' avoidance behavior were particularly pertinent: "Opting to take the path of least resistance, we opt to avoid or deny what is making us anxious."

As the students unrelentlessly refuted the issues, the clinician attempted to clarify his intentions (and, it might be said, the objectives of the workshop): "I am trying to point out to you signs that you will recognize when you are at a critical choice point. I'm trying to raise your level of consciousness so that you can see whether or not you are automatically behaving in dependent ways. And I'm suggesting to you that sometimes you might think about behaving in independent ways. I think as a result of this, you will begin to feel that you have more to say about your life and that you are more in control of your life. I think as a result of this, you will look at yourself differently (that is, your self-concept will

change), and I think your self-esteem will rise, because when we feel more in charge of our lives our self-esteem is affected."

It is of interest that the clinician interjected the definition of learned helplessness; however, he did not associate the concept with the students. He depicted it rather as an "extreme example of dependency." He discussed the ways in which people project blame onto their environments for controlling them, and how they talk about not having any freedom when, in reality, they have never tested the belief. Further, he suggested that in relationships individuals must recognize the ways in which the behaviors of other people are reinforced by our own behaviors (i.e., "Men won't pick up their own dirty socks because you continue to pick the socks up for them."). He suggested that is is very important that we scrutinize our own behaviors to see if they are reinforcing those of the other person. He stated that through self-motivation, we encourage undesirable behaviors in others which, in turn, serves to perpetuate our own maladaptive behavior.

Students demonstrated that the third step of the ACT formula, taking action, was the most difficult for them to accept. This is not surprising when one considers that until now students have been considering feelings and cognitions. The clinician has now encouraged them to translate talking, thinking and feeling into "doing" and has challenged them to activate new behavioral repertoires.

SESSION EIGHTEEN: PHYSICAL INDEPENDENCE

A. Objective

1. To introduce students to the topic of physical independence.

B. Curriculum Outline

1. Letting go of physical dependencies.
    a. Why questions.
    b. Physical dependencies.
    c. Choosing to end the relationship.
        (1) The four stages of ending a relationship and/or breaking an old habit.
        (2) The obstacles that stand in the way.
            (a) The hopelessness obstacle.
            (b) The morality obstacle.
            (c) The motivation obstacle.
            (d) The environmental obstacle.
            (e) The goals obstacle.
            (f) The lack-specific plan obstacle.
    d. Rules for applying the twenty-one-day choice program.
2. Take home exercise: Emotional Independence Inventory (see Appendix E).

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I wanted the students to pay close attention today. There was a section in my presentation that I felt they would not be able to

remember (i.e., "the twenty-one-day program to break a bad habit"), so I alerted them to this at the beginning of the session. I wanted them to be able to associate the "name" of the day with what they were supposed to be doing that particular day. They were very enthused about this topic related to letting go of their physical dependencies, and at least half of the students prepared themselves to take notes and did so.

During the first part of the presentation, I tried to explain the analogy between having a relationship with someone (that you want to end) and having a relationship with some behavior (that you want to break). I talked to them about the four stages one goes through when dropping a long-standing relationship - the same stages that one goes through when dropping a habit. I discussed the magical stage (e.g., when you say, "This relationship isn't that bad"), the illusion stage (e.g., when you say, "The problems with our relationship may work themselves out"), the trying stage (e.g., when you try a variety of solutions and often trial separations from the habit), and the last straw stage (e.g., when you become disgusted with the habit or the costs outweigh the benefits in a clear way).

Next, I wanted to identify some of the obstacles they would probably run into along the way when trying to break their old habit. I talked to them about the hopelessness obstacle in which they believe nothing works, therefore they don't act and, of course, nothing happens. I wanted them to think about the ways they deceived themselves (e.g., by saying, "I'm naturally _____"); I explained that they were in effect saying, "I choose not to put forth the effort." I

also discussed the notion that when they say, "I don't care," they do care or they wouldn't feel bad about doing it.

Next, I talked about the morality obstacle in which they tell themselves things like, "I'm no damn good," or "What difference does it make?" I wanted the students to see how blaming themselves was like indulging in a kind of neurotic pleasure: they feel remorse, they castigate themselves, they feel purged and then go out and repeat the same wrong actions over again.

With the motivation obstacle, I pointed out to them that motivation can work backward. They first have to have some success, then they will feel motivated.

The environmental obstacle had to do with the need to put some distance between them and the environmental cues that lead to the habit.

The goals obstacle required alerting the students to the fact that choices are better than goals when trying to break an old habit. In this regard, goals create resistance, disappointment, and relapse.

Finally, I talked to the students about the need for a specific plan, and introduced them to the twenty-one-day choice program. After a brief introduction and instructions, I took one day at a time, "named" the day (i.e., Day One: Wake-up Day), and then described what they were to do on that day. On each day they were to set aside two ten-minute review periods and each day think of and confront and experience the realities that come with the process of breaking a habit. Each day, after facing these realities, they were to say to themselves, "Nevertheless, I am choosing to let this habit go." The

students were very enthused about the discussion and found it relevant. I think a few of them will try it!

E. Researcher's Validation of Instructional Intent and Comments

The tape verifies that the curriculum was followed according to the clinician's narrative and the curriculum outline.

At the beginning of the session, the clinician urged the students to consider two significant factors which relate to the modification or extinction of an existing behavior: (a) People very often engage in self-defeating behaviors not because they enjoy them, but because they perceive that they would be uncomfortable without them (e.g., staying in an unhealthy marriage, smoking, overeating), and (b) There are many things in life that we must do something about before the appropriate feelings associated with the action can catch up. He explained that if people wait for the feeling to be just right, they might remain impotent in the participatory stage and become fixated at that point.

There was very little student participation while the clinician presented the obstacles which tend to be deterrents to ending an old habit. The clinician's presentation was didactic and therefore teacher-centered; it was not intended to elicit group interaction. An aura of excitement surrounded the clinician's presentation of the twenty-one-day program, however, and students seemed to be very motivated to try to implement their own plans for changing undesirable behaviors. The clinician disclosed his personal interest and confidence in the program by sharing with the students that he planned to use it to lose weight. He also revealed that one of the

salient features of the plan has to do with the fact that the program confronts reality, and requires that the person be in control of the "letting go" process. In addition, users of the plan practice a type of self-talk which continuously reminds them that they "are choosing to give up the habit." The clinician stressed that the plan was particularly worthwhile because it systematically encouraged students to take an active stand when choosing new ways of behaving and did not underscore any need for unhealthy avoidance behaviors.

The students' enthusiasm became evident when the clinician concluded his discussion and asked if there were any questions. The students asked for clarification and interpretations and seemed to be excited about putting the plan into action.

SESSION NINETEEN: EMOTIONAL INDEPENDENCE

A. Objective

1. To introduce students to the topic of emotional independence.

B. Curriculum Outline

1. Emotional independence.
    a. Discussion of the two different emotional systems.
        (1) "Others are responsible for my feelings and I am responsible for their feelings."
        (2) "I am responsible for my feelings and you are responsible for yours."
    b. Messages that emotions transmit.
    c. Acknowledging and accepting one's emotions.
    d. Payoffs.
    e. Action.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I wanted to talk to the students about emotional independence, and about taking responsibility for their emotions. I wanted them to realize that they had two emotional systems from which to choose: one represented by the belief that "Others are responsible for my feelings and I'm responsible for theirs" and the other depicted by the belief that "I'm responsible for my feelings and you are responsible for your feelings."

I wanted the students to see that when they operate out of the first system (the dependent one), they have to wait for the other person to change so they will feel better, and they become frustrated when he or she doesn't. I went on to explain that they then start to feel helpless to change the situation and then hopeless that anything will change. Eventually they become dispirited and resentful toward the other person. As a result of this sequence of events, communication between persons breaks down. The reason for this is that when you believe that what you say is responsible for how the other person feels, you won't say anything meaningful. The other person then begins to think the same way and, as a result, intimacy disappears. When they are emotionally independent, they operate out of the emotional system that says, "I'm choice-able for my emotions and you're choice-able for yours."

I wanted the students to think differently than they are usually accustomed about painful emotions. I wanted them to see that painful emotions aren't trying to punish them, but to wake them up and get their attention. I then talked to them about the distinct messages that I felt each specific group of emotions was trying to send them. For example, when they are anxious the message is either that they are in danger and should protect themselves, or they are exaggerating the danger and should think more realistically. Further, when they are angry, it can be an indication that they need to take action against someone who is infringing on their domain, or that they mistakenly think an infringement is occurring. I wanted them to see that emotional pain is like physical pain in that both tell us

something is wrong that needs to be corrected. If they ignore either, the pain persists and the problem usually gets worse.

I explained to the students that the first step in being emotionally independent is to acknowledge and accept their emotions. By doing this, they send the message back to their brain that they realize something is wrong, but that they will take care of it. Once they do this, the severity of the pain immediately starts to lessen.

One statement that I made to the students about owning their own emotions, especially their negative feelings, in particular, got them reacting and discussing their feelings with me. I told them that when they are emotionally independent, they don't say, "I'm not depressed," nor do they say, "You're making me depressed." What they do say is, "I'm depressing myself today." At this point I underscored that we create our own feelings. They found this difficult to comprehend and an even more difficult concept to accept. What was I saying? Was I telling them that they were actually wishing negative feelings upon themselves? And didn't their environment play a major part in dictating how they felt? I tried to explain to them that I was trying to get them to modify what I considered the typical way of looking at one's feelings, i.e., that our environment and others are responsible for the way we feel. I wanted them to see that we have a mediating ego, that we can choose how we are going to feel and, while our environment can precipitate things and increase the probability for certain feelings to be elicited, we have the last word and can decide how we are going to feel about it. In addition, I pointed out that we tend to hang onto

our negative feelings. I discussed the "payoffs" with them and they were able to relate to them.

I ended the session by talking to the students about the positive aspects of being direct with people about their feelings.

E. Researcher's Validation of Instructional Intent and Comments

The tape confirms that the curriculum was followed as planned. As the clinician's narrative suggests, his attempts to help students understand that they create their own feelings were futile. The students' protests demonstrated that they were not able to grasp the clinician's assertions. By way of illustration, one student said, "I cannot understand why a person would 'choose' to be depressed." Another disclosed, "It seems totally unrealistic to think that we could control our own feelings." To these the clinician responded, "If you are acting depressed, you have to at least own your part in that," and "There is an important shift of emphasis here: from attributing feelings to our environment to saying that we are responsible for what we are feeling."

As the discussion progressed, the clinician repeatedly attempted to convey that what he was trying to communicate "is that we stop blaming others (or the world) for the negative feelings we have, and begin to acknowledge and accept how we feel and begin to do something about that." Throughout the session, students seemed to interpret this message as one which conveyed: "we 'should' not feel negative thoughts." The clinician tried to dispel fallacious thinking by giving numerous examples of times when it is appropriate to feel negative emotions. He emphasized that the thrust of his message was that we own the emotion, feel it, and experience it, but not hold on

to it when it begins to get in the way of full functioning (e.g., persistent pathological mourning of a loved one). The clinician's remarks appear to smack at the very heart of the theme of the workshop: "Don't like it the way it is? Change it!" The clinician also pointed out that there are certain "payoffs" (i.e., secondary gains) inherent in dysfunctional behavior, and he urged students to ask themselves if the "gain is worth the pain."

As the clinician's narrative suggests, he attempted to stress that emotional independence is predicated on the idea that people can only control their own feelings, and that it is a mistake to try to take responsibility for others' feelings. He explained in some detail that "when we feel responsible for the other person's feelings, and the other person doesn't change, we become resentful and angry and often suppress or repress our hostility which manifests itself in indirect ways" (i.e., displacement). In addition, he noted that while we can't change other people, we can try to understand others' feelings "by trying to get into their phenomenological fields (i.e., get into their fields of perception) and try to see things the way they are perceiving them." This statement stimulated dialogue between one student and the clinician about the problems associated with making faulty assumptions. The clinician stressed, "If you want to understand people, you must seek information from them through verbal and nonverbal behavior. You are going to have to inquire and not make assumptions." He pointed out that if assumptions are made about another person's phenomenological field, one of the cardinal rules of assertiveness is broken, i.e., no one is a mind reader.

The clinician communicated to the students that the motive behind ignoring emotions relates to not wanting to confront the reality that something might be wrong with us. He encouraged the students to become responsible for their feelings and to acknowledge and accept the way they are choosing to feel. It was at this point that students began vigorously to refute the notion. Their rationalizations and arguments were reminiscent of sessions thirteen and sixteen at which time the clinician's discussion also revolved around the topic of individual choice and accepting responsibility for one's own feelings. The students were very verbal and openly resistant to the suggestion that man can be a free-will agent. Admittedly, the concept is complex and probably difficult for students to comprehend. It would be suggested by this researcher that the notion of "choice-ability" is particularly problematic for reactive individuals whose feelings have become conditioned, reflexive responses to what they perceive as externally imposed stimuli. It should be pointed out that the clinician's presentation is heavily grounded in existential philosophical principles which underscore the importance of the ability to "own" one's own life and conduct, and to be autonomous (May, 1967). In this regard, to accept the basic tenets of existential thought, individuals must also recognize their capacity for direct access to the internal mechanism for choice-making; they must also actively confront and experience discomfort in order to open up new possibilities for fully living. The clinician challenged the students to maximize their potential for fully experiencing the process of personal living when he responded to the following student-initiated question: "Why do you make it all sound so difficult?"

He replied, "If I don't make you uncomfortable for a while, you won't see that there are other options in terms of the way in which you operate. Being comfortable is how we stay emotionally dependent."

SESSION TWENTY: EMOTIONAL INDEPENDENCE (Cont'd)

A. Objective

1. To conclude the discussion of emotional independence.

B. Curriculum Outline

1. Emotional independence (Cont'd).
    a. The difficulty of acceptance.
    b. Guidelines to help you choose how you want to feel.
    c. Steps to practice quitting.
    d. Discovering your problem areas.
        (1) Questions to ask yourself.
        (2) Ask others.
        (3) Write your autobiography.
        (4) Analyze dislikes.
        (5) Emotions as signposts.
2. Take home exercise: Social Independence Inventory (see Appendix F).

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I intended to talk to the students about reasons why they tend to hang on to their negative feelings. It has to do with not wanting to accept the situation as it is, without judgments. Hanging on to negative feelings also has to do with not wanting to lose control. I explained that they might think choosing to accept unwanted events (and feeling good about that) may be a sign of giving in, or letting

others or the world win. They may use their bad feelings as a method to not let others (or events) get away with what they did to them.

We discussed the idea of staying angry because they didn't want the other person to get away with what was done. We also talked about nursing hurts (which proves how uncaring and unfair the world is), and about keeping themselves scared in order to remind themselves and others how important and dangerous something is. I also spoke about their tendency to make feeling bad seem so important. I mentioned the martyr type to them: the person with the "victim mentality." We talked about what I call the "broken record syndrome": the tendency for people to repeat to themselves things about themselves that keep them in a bad place. Some of the students seemed to be able to relate to this concept and listened intently to my advice. I suggested that they test reality and perceive whether they still felt about themselves the way they were habitually talking to themselves and, if not, to start sending more positive and kinder messages to themselves.

I also talked to the students about the importance of experiencing negative feelings, but then choosing what they wanted to do with them. I explained that it was not healthy to deny them, and that they needed to be experienced, but that it was healthy to let them go. I used expressions like, "healthy surrender" and "going with the flow" as opposed to resisting or fighting the feeling or tenaciously holding on to the feeling. "Experience it, but let it go" was what I tried to impress upon them.

I also talked to them about the difference between expressive behavior (in which they vent their feelings and have their catharsis) and operant behavior (in which they experience the feelings, but then choose how they are going to behave with them, and act in such a way that they shape and mold the other into responding to them in a way that benefits them).

We also talked about how thoughts and feelings are related and how they might be able to change how they feel about something if they could change how they think about it.

We also talked about how our past tends to depress us and how our future tends to make us anxious. I explained that it was imperative that we try to stay as much as possible in the present.

I offered the students some guidelines that I thought might help them choose how they want to feel. I suggested that they make a list of twenty times they have felt bad over something and then ask themselves, "How much good did the feelings do me? Were they necessary? Where did they get me?" I also recommended that the students list some traits or beliefs that they have come to feel differently about in order to demonstrate that they do have a choice. I suggested that trying could help them choose not to feel bad: trying simply requires choosing to do it. I recommended that the next time they felt bad, they decide that they are not going to feel bad and see what happens. I concluded this discussion by explaining that one of the best ways to see their choices clearly is to exaggerate them.

I was unable to talk to the students about the steps to practice "quitting" and could not include the material related to the discovery

of their problem areas. There wasn't enough time, because we had spent too much time talking about these other issues.

E. Researcher's Validation of Instructional Intent and Comments

As the clinician's narrative points out, as a result of the social interaction which was evoked from the topic related to the difficulties inherent in freely choosing how one wants to feel, he was unable to complete the topics entitled, "Steps to practice quitting," and "Discovering your problem areas." The tape confirms that the remaining subject matter was covered as indicated in the clinician's narrative.

When the session commenced, the students seemed highly aroused. There was a great deal of informal, spontaneous talking and joking between the clinician and a number of students. He candidly pointed out that everyone seemed "all wound up." The students asked him if he was going to be at their graduation, to which he replied in the affirmative. One student responded, "Oh! That's kinda neat!" Another asked how his diet was "going." He answered, "I have lost three pounds." Extemporaneous, conversational dialogue became prevalent throughout most of the session. Students offered personal disclosures which required a good deal of risk-taking, and their attitude toward the clinician seemed to this researcher to be more open and less contentious. In general, the students seemed less judgmental and far more willing to listen carefully before presenting their own opinions. This new posture did not deter them, however, from openly disclosing their cognitions and feelings about related issues.

It continues to be of interest to this researcher that the more intimate self-disclosures have been emitted by younger students (judging from the verbal content). The older students tend to be resistant to the issues revolving around independence as well as inflexible in their willingness to move beyond that which is familiar cognitively, emotionally, and behaviorally.

During this session, the clinician confronted the students by asking the following questions: "Why is it that we feel if we accept bad feelings, we're going to be worse off? Can any of you shed light on that? I think I am having a heck of a time convincing you otherwise, some of you." A student responded with a personal disclosure about feeling angry for having "no talent, whatsoever." After a great deal of venting, the clinician responded to the student: "It just strikes me that rather than lament or feel badly about the things you started and didn't finish, you need to look at your life in terms of what you can do starting now . . . because this other stuff is passed. I don't know whether you agree with this or not, but it seems to me that when we tend to dwell on the past, we run the risk of getting depressed. And when we project ourselves into the future, we run the risk of getting anxious. So we are best off if we stay in the present, as much as we can, and decide what we can do about it. I think we do have a lot to say about our future if we can get our act together in the present." The clinician went on to disclose to the student that he felt she might want to take her share of the responsibility where it is appropriate, and say, "That's the way it was, but that doesn't have to be the way it has to be from here on in." By responding to the student in this fashion, the

clinician allowed the student the opportunity to understand herself more clearly in the here-and-now and at the same time he provided encouragement and support that communicated that she is capable of effecting change. The clinician linked the student's disclosure to the main purpose of the workshop by saying, "That is what the workshop has really been about: taking responsibility for our own life and owning it and saying we can do something about making our own life different for ourselves, even though we have the past to look at and there are things that we regret." He also shared, "When you think you have nothing, you need to listen to people who think you have something! We must let other people in and let them come at us with the positive things they have to say, and not shoot those things down or think they are trying to manipulate us." He explained that if we don't learn to do this, our self-esteem is not going to increase at all. "Let the past go. Part of expanding your personality is to believe that there are yet undiscovered things about yourself that you can begin to practice so that you might become a different person. The clinician recommended that students say to themselves, "I am not going to let my feelings get in the way of getting something I want." He stressed that he wasn't advocating that they deny their feelings, but that they experience them, then let them go or they will get in the way. As noted during the previous session, such a position is highly suggestive of the free-will concept commonly associated with existential philosophical ideology.

During the session, the clinician moved away from the program format to explain the difficulties associated with "letting people in." He briefly discussed Erikson's (1963) hypothesis of the first

stage of psychosocial development during which a child negotiates the trust versus mistrust crisis. The clinician communicated that one's level of trust "depends upon how responsive our caretakers are during the first year of our lives. The child who learns not to trust will later look at the world as a place not to be trusted." This latter issue brought up the associated topic of nurturing. The clinician reiterated an earlier observation that students "may have a larger need to nurture than to be nurtured. If that is the case, it may be harder for you to be nurtured. Very likely the relationship that you have of intimacy will be with someone who needs to be nurtured if you have a large need to nurture, and then you are not going to get what you are looking for." To recognize that there may be trade-offs for being polarized at the far end of the "rescue continuum" may be an important insight for women, particularly those who have chosen to perpetuate their nurturance through work in the helping professions.

The clinician concluded the session by challenging the students to choose to alter their feeling states the next time they feel bad. He reflected, "Last time I think this concept met with resistance because we ended up wondering about whether we could actually choose not to feel bad when we were in a situation in which we thought bad feelings were being elicited from without. Can you see yourself as having this power?" After a brief dialogue with an older student (who was able to concede that choices can be made <u>after</u> a person has had a chance to think about it), the clinician conveyed that he would like to have students cut down the latency period. He stated, "If you will agree with the premise that for the most part thoughts

precede feelings (and sometimes the feelings seem almost reflexive), can we not choose to think differently about the thing even as it is happening? That would take a lot of practice and would require a real change in our thinking that we can do it right then as it is happening." Once again, he emphasized that while anger may be the appropriate feeling state, "feel it, experience it, but then decide what you want to do with it." He then encouraged the students to ask themselves regularly, "Are we doing life, or is life doing us?"

A personal disclosure followed, in which one of the students indicated that her relationship with her mother has improved since she has begun to choose not to continue to use expressive behavior with her parent. The student explained that she was choosing to remain calm in order to talk the problem through with her mother (a disclosure that exemplified the effective use of operant conditioning to modify her environment while attempting to achieve a desirable outcome behavior).

SESSION TWENTY-ONE: SOCIAL INDEPENDENCE

A. Objective

1. To introduce students to the topic of social independence.

B. Curriculum Outline

1. Social independence.
    a. Introduction
    b. Social isolation
    c. Intimacy
    d. When in trouble, think the reverse.
    e. Creativity.
    f. If a dog runs at you, whistle.
    g. Anything worth doing is worth doing poorly.
        (1) Stop trying so hard.
        (2) Make yourself vulnerable.
        (3) Don't just do something, sit there.
        (4) It's easier to do than to say.
        (5) You get more with less.

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

I intended to talk to the students about social independence. My outline called for me, first of all, to characterize social independence by pointing out to the students that when they accept themselves, they are free to accept others; and when they accept others, others want to be around them. I discussed the notion that

when they are socially independent; they meet others as equals, they deal directly with others and others deal directly with them. As a result, they know where they stand with the important people in their lives. I also explained that when they can take care of themselves socially, they don't feel compelled to maneuver people into taking care of them; while manipulation can get them what they want in the short run, in the long run they end up with people tending to avoid them.

Next I talked to them about social isolation and made the point that this usually results from the dependency cycle, because when they believe they need others to support them, they drive them off. This becomes a vicious cycle: the more others move away from them, the more they try to grab on.

I then talked to the students about intimacy and related it to what one experiences in a chum relationship (i.e., special warmth, sharing of each other's innermost being, confidentiality earmarked by a free exchange of each other's vulnerabilities). I also talked to them about the "illusion of fusion": the belief that they can become one with another. This illusion feeds dependency because it encourages people to search frantically for perfect understanding from the perfect person. Frustration is the order of the day for the rest of one's life for the person who pursues this course, because one can never become one with another; no matter how close the relationship, we always remain individuals.

Then I gave them some things to think about in trying to become more socially independent. Overall, I wanted them to see that becoming more socially independent requires thinking in reverse.

For example, instead of trying to get people to like them, try to like people; instead of trying to hide their flaws in social situations, expose them; instead of trying to defend themselves from criticism, agree with the kernel of truth in the criticism. The students particularly reacted with surprise about my advocating exposing their flaws. They asked me for examples and I gave them a personal one about how I acknowledge my anxiety when I feel it in a situation in which I'm performing in front of a strange audience (this relieves my tension and theirs).

I then presented some sayings that were familiar to the students which I turned around to get them to think in reverse (e.g., "If a dog runs at you, whistle"). I then talked about being willing to face the naked truth, and that in doing so, fear and danger disappear.

I then discussed the idea that "anything worth doing is worth doing poorly." I stressed that if it is worth doing, it is worth doing no matter how well it is done. Looking at performance in this way means getting into the process rather than the end. In this way one eliminates the possibility of judging worth in retrospect.

I talked to the students about the wisdom of healthy surrender, of going with the flow. I advised them to stop trying so hard to make people like them, to stop trying so hard to please others, to stop trying so hard to get people to understand them, to stop trying so hard to solve other people's problems, to stop trying so hard to improve others, and to stop trying so hard to hide their own flaws.

I spoke to the students about "the wisdom of insecurity": instead of trying to protect themselves at all costs, to make themselves more vulnerable. I gave them some practical examples of

what this entails (e.g., with regard to social anxiety, openly expect that they will get anxious around others; look at their anxiety in a detached way; don't fight it; accept it and let it be; self-disclose about themselves; don't blame others).

Finally, I talked about the concept, "don't just do something, sit there." This really appealed to them! I stressed the advisability of taking no action at times, of giving themselves time to think, of not impulsively asking for help when they could do things for themselves, of not overreacting to others but giving themselves some time to think. I encouraged them not to run at the first sign of their panic.

This session elicited a number of dialogues and the overall interest was high. One could readily perceive the relevancy of these ideas for the students.

E. Researcher's Validation of Instructional Intent and Comments

The tape reveals that the clinician covered the subject matter as indicated in the curriculum outline and personal narrative. Additional material was presented, however, which made the session of particular interest to the students. The primary focus of the session related to the mechanisms which tend to precipitate social dependence, and the techniques which can be utilized to increase one's potential for achieving social independence.

At the beginning of the session, after briefly introducing the concept of social isolation, the clinician deviated from his curriculum guideline to present a more in-depth look at the meaning of intimacy. He stressed the importance of maintaining individuality and separateness

and asked the students to consider the implications of "fusion" with another person (i.e., "becoming one with someone else"). He asked the students, "Do you think it is fair to say that some of us have been encouraged or have been taught to try to find someone with whom we are supercompatible so that we can be one-minded or single-hearted?" Because there was no response to his question (albeit apparently perceiving that absence of response does not necessarily connote a negative reaction), the clinician pressed on by stating, "I'm thankful for that, because perhaps you have been raised realistically with regard to this. If any of you have been searching for that perfect person, though, than I guess it is worthwhile for you to think about this: that it is an illusion." He then asked, "What is intimacy?" Again, there was no response evoked by the question; therefore, the clinician continued by conceptualizing those qualities which tend to be characteristic of an intimate relationship. He pointed out that it is not a given that all people experience intimacy. In addition, he suggested that when individuals don't find intimacy within a relationship, they often seek it elsewhere when, in fact, the "best bet is to see what you can do with the situation that you are in to make it better." From the limited amount of response resulting from the discussion of intimacy, it appears that this was a "high risk" area that students did not want to pursue.

The first student response for the day emerged out of the discussion, "Anything worth doing is worth doing poorly." The students had a great deal of difficulty accepting the basic premise of the idiom. One older student sounded particularly disconcerted as she noted, "That

is not what I try to teach my kids. Why do it crummy? It's not worth doing if you do it that way." The clinician pointed out that she was not thinking in reverse as he was attempting to have them do. He suggested, "If you conclude that it's worth doing at all, then it's worth doing, and its worthwhileness in doing it is not contingent upon whether you're going to do it well. That's not where its intrinsic worth comes from. It comes from your position that this thing is worth doing." He went on to explain that if a person was to perform in a certain way and then find out that her performance didn't turn out well, it would be a mistake to then conclude that it was not worth doing. He continued, "I think more of us would enter into something (and probably do a better job at it) if we took the pressure off of ourselves" and looked at the results not in terms of failure but in terms of the worth in having performed the act. Associating the students earlier response with this idea, the clinician stated, "With our children, we need to praise the effort and next present them with a standard of excellence toward which they can strive." He explained that many parents criticize the acts of their children instead of praising the effort. In this respect, they talk about the standard of excellence first. He pointed out that particularly when individuals have a perfectionistic bent they can be very hard on themselves, and such an attitude can also be projected onto others around us. This issue inspired further discussion regarding individuals' needs to do well in order to feel OK about themselves. He encouraged students to become more process-oriented, i.e., to find meaning in the process, as opposed to the end result, and to get more involved in the "doing."

Several disclosures surfaced during the session which demonstrated that many of the students are perceiving change within themselves. One student confided, for example, that it has been very difficult for her to understand the comment that has been made to her to "stop caring so much." She shared that she now understands that this can be translated into, "You're going overboard." The clinician reinforced her insights and responded, "Yes, I think whenever we have any characteristic that predominates in our personality, it may be something we need to modify." He gave a theological and psychological interpretation of how we can modify our behavior (and thereby change) without discarding the behavior entirely. He stated that "we prevent ourselves from changing when we think of the other extreme (i.e., I don't want to become an uncaring person)."

The clinician then raised some very thought-provoking questions regarding the "wisdom of insecurity" and shared personal disclosures to clarify the concept. He suggested that when students are anxious, they might attempt to make themselves more vulnerable. In so doing, they acknowledge the fear and this can help them become stronger in the process. He added, "It also opens the door for other people who have been wondering whether they could expose themselves to do so. Openness begets openness, directness begets directness, and authenticity or emotional honesty begets emotional honesty." The clinician stressed that by confronting the reality of the fear, one cannot disguise or deny its existence. The clinician's interpretation of the "wisdom of insecurity" appears to closely parallel the concept of "paradoxical intention," a technique commonly associated with

Logotherapy. As Viktor Frankl, the founder of Logotherapy, posits: "On the two-fold fact that fear makes come true that which one is afraid of, and that hyper-intention makes impossible what one wishes, Logotherapy bases its technique called "paradoxical intention" (1963, pp. 195-196). According to Frankl's theory, if a person fears that his hands are going to sweat, he is invited to intend precisely that which he fears (i.e., profuse handsweating) in order to reduce underlying anticipatory anxiety and extinguish the behavior.

As the session progressed, the students became more responsive. The topics which were covered appeared to provide the students with insights which were related to what one might characterize as the delicate balance between sensitivity toward self and others and a prudent, professional objectivity required of health-care personnel. Throughout the sessions, the clinician has repeatedly attempted to convey that while we can "own" responsibility for our personal cognitive, emotional, and behavioral choices, we must recognize that we can only encourage others to become choice-able; we cannot directly make the choices for others, nor change that which they do not intend changing, without experiencing negative consequences. In this regard, having a "fix it" or "rescue" complex can be counterproductive for the other person and can quickly deplete the rescuer of her own emotional reserve.

SESSION TWENTY-TWO: YOU ARE THE MOST IMPORTANT PERSON IN THE WORLD

A. Objective

1. To discuss the implications of being the most important person in the world.

B. Curriculum Outline

1. "Who am I?"
   a. The relationship between "Who I am" and independence.
2. The implications of being the most important person in the world.
   a. Behaviors that will cease.
      (1) Needing comparisons.
      (2) Demanding perfection from yourself.
      (3) Being a pleaser.
      (4) Being a big shot.
   b. Behaviors that will emerge.
      (1) Improving relationships with others.
      (2) Operating in your own best interest.
      (3) Making a contribution to others.
      (4) Treating yourself well.
      (5) Opening up your potential.
      (6) Applying the ACT formula automatically.
3. Student evaluation of Medical Assistant Pilot Program (see Appendix G).

C. Primary Source of Instruction

1. Emery, G. (1982).

D. Clinician's Narrative

This was the last session of the workshop. My intention was to put a capstone on the workshop by talking about each of the students being the most important person in the world.

I went back to the beginning of the sessions when we had talked about our identity and the students tried to answer the question, "Who am I?" This time I stressed that the question they needed to ask along with "Who am I?" is: "Who needs to know?" I told them that they were the only ones who ever needed to know the answer to this question. I explained that this was fortunate, because they were the only ones who could experience who they are.

I then raised the rhetorical question, "Someone has to be the most important person in the world, and who better than you?" I proceeded to give the students ideas to think about in this regard (e.g., "Who has the power to invent the world you see? Only you can make your adversaries ten feet tall and yourself ten inches high. You are the one who can assign meanings to your experiences. You are the only one who has the power to control how you think, feel and act. You are the only one who can have your experiences.").

Then I wanted them to understand the implications of their believing that they are the most important person in the world; therefore, I gave them the following propositions to think about within this context (and I commented about each):

1. You have no need for comparisons. No matter what others accomplish, you always remain more important.

2. You stop demanding perfection from yourself. Once you realize you are "king," you don't have to be a slave to perfection.

3. Your fear goes away and you no longer have to be a pleaser. When your importance comes from others (or so you believe), you are always afraid it will lessen and that others will somehow take it away from you. In reality, you can never become less than the most important person in the world, therefore you stop becoming a pleaser. In this regard, you don't give more power to others and hold them up as your betters; you stand up for yourself, you don't discount yourself, and you don't let others discount you.

4. You stop trying to be a big shot. When you are on top (and realize it is your birthright to be there), you free yourself of having to try to impress others.

5. Your relationships with others will improve. You start to realize that all people are the most important persons in the world to themselves, so you stop trying to get them to think that you are more important than they are.

6. You begin to operate in your own best interest. You know you can't become more than the most important person, therefore you don't have to achieve to prove to others how important you are. You achieve because this is what you want to do for your own best interest.

7. You can make a contribution to others. When self-respect is high, you feel free to help others. You have a desire to help others. When self-respect is down, you have a desire to bring others down.

8. You treat yourself well. You take care of your health and treat the most important person in the world (yourself) with respect.

9. You open up your potential. You realize that the vast majority of your perceived limitations are illusions. You place them on yourself because you don't realize your importance.

10. You start applying the ACT formula automatically. You accept yourself. You are free to choose to be independent. You take action that is in your own best interest. You let the RAT formula (Resisting reality, Allowing dependence, and Taking dependent action) go.

Overall, the students seemed not to be as responsive today. I think the fact that it was the last day of the workshop had something to do with it. In many respects, I believe the second-to-the-last session was their last. They seemed spent.

The evaluation followed. The students completed their assessments of the workshop quickly.

E. Researcher's Validation of Instructional Intent and Comments

The tape reveals that the clinician completed the curriculum for the final session as planned.

The intention for the last session was to have the students perceive the implications involved in being the most important person in the world. By reflecting back to the session in which the students were first asked to consider the question, "Who am I?," the clinician once again demonstrated that dependent people will typically answer the question in terms of those to whom they are attached. Conversely, he indicated that if an individual answers the question as an independent person, she will typically envision the "I" as a separate entity.

At the beginning of the session, it became relatively clear that students continue to have difficulty perceiving their separateness from external associations. By way of illustration, the clinician began to focus on some of the behaviors that tend to disappear once an individual begins to overcome dependency. Hence, he spoke about perfection and asked, "Why are we striving for perfection when we are already the most important person in the world?" A student responded, "Do you mean as a person or by the things we do?" When the student was asked, "Do you differentiate between the two?" she did not offer an answer. He then asked, "Do you mean, 'Now that you are king, behave like a king?'" The student responded, "Yes." While the exchange is important in that it underscored the phenomenological theory of congruence - the concept which refers to the "matching of organismic experience, awareness and communication" (Rogers, 1961, p. 339), the student's response seemed to circumvent the real issue. The clinician's inquiries appeared to be directed toward helping students recognize that perfectionistic striving is dysfunctional and is not comparable to, nor compatible with, a healthy tendency toward self-actualization which can enhance the experiencing organism. The clinician's comments also seemed to communicate the notion that there may exist an inverse relationship between one's perfectionistic strivings and the individual's personal perception of self-worth. In this regard, the clinician stated that the self-actualization process is something that is not "attainable," and "those who strive for perfection have a self-worth that never quite measures up." He continued the discussion by sharing, "These people have to tell themselves that they already are important

and that their self-worth is not predicated on whether they achieve this perfect state or anything close to it." He explained that it is precarious to base self-worth on externals (e.g., achievement, others' appraisals of us, etc.) and noted that "self-acceptance, while connected with externals, must stand alone. Self-worth cannot depend upon others' appraisals of us because when others' perceptions change, so then will our self-appraisals." The clinician continued the discussion by talking about the vulnerabilities which tend to emerge when an individual's sense of self-worth is predicated on others' appraisals. He spoke of the problems associated with the "harp and halo syndrome" and "pedestalitis" and disclosed that most of those with whom he is involved in a therapeutic relationship confide that they prefer not to be placed in positions in which they are revered because of the difficulties inherent in living up to externally imposed expectations. The clinician also explained that egalitarian relationships of intimacy are formed when both people feel secure and adequate and recognize that all people perceive themselves as the most important persons in the world.

The clinician also discussed the concept of "altruism," which he noted appears on the surface to have others' interests at heart. He pointed out that, psychologically speaking, "We operate in our own best interests." One student argued the point by saying, "It is nice to have other people in life to make you want to go ahead . . . . other than just yourself." The clinician clarified his position by sharing that he was not saying that we take it to the extreme and only operate in an either/or fashion (i.e., "just take care of yourself"). He offered the example, "It's not good for me to hurt

you," and suggested that as he said this he was still using himself in terms of a point of reference, "as opposed to having other things from the outside control me, that is, in terms of how I want to relate to you. I'm taking responsibility for that and I'm saying (for my own psychological well-being), 'I'm going to try to relate to you in a positive way.'" The clinician then disclosed that "we choose to decide how we're going to respond and I don't think it's a selfish thing to do. I'm talking about healthy selfishness, and the fact that we are the ones who are choosing to do whatever it is that we are trying to do for the other person." The students appeared to have a great deal of difficulty understanding this concept.

The final two questions that were asked elicited no response from the students. The clinician asked, "Do you think that love of others begins with love of self, and love of self begins with love from others?" Because the question went unanswered, the clinician asked the following closely related inquiry: "How do we come to be so intropunitive?" (The clinician defined the term as "putting oneself down.") Again, the students would not respond. Why the students were so guarded, sullen and detached remains, for this researcher, a moot point. As the clinician has suggested, the students may have lacked the motivation to actively participate in any further discussion of this nature. In addition, this researcher believes that the clinician's questions were provocative in terms of their philosophical, theological, sociological and psychological underpinnings, and students perhaps lacked the sophistication to actively confront the complexities associated with the inquiries.

As noted in the clinician's narrative, the students completed their evaluations of the workshop very rapidly. A discussion of the results of these assessments can be found in the dissertation to which this handbook is supplemental.

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APPENDICES

Appendix A

ME! AN EXERCISE IN GETTING TO KNOW MYSELF BETTER

Just for fun, try completing the following statements. There are no "wrong" answers if they are your answers.

ME!

My favorite color is . . . . .

My favorite food is . . . . .

My favorite smell is . . . . .

My motto is . . . . .

If I could live anywhere I pleased, I'd be living . . . . . .

My dream job would be . . . .

I wish I were bold enough to . . . . . .

Sometimes I wonder if . . . . . .

In five years I want . . . . .

I laugh when . . . . .

I feel sad when . . . . . .

I get angry when . . . . . .

I am sorry I never . . . . . .

My home is . . . . . .

My favorite people are listed here with one word that best describes each:

_____

_____

_____

When I grow up . . . . .

I love to . . . . . .

My favorite things include . . . . .

I wish I knew more about . . . . . .

I have never told anyone that . . . .

If I were 18 again, I would . . . . . .

I am afraid of . . . . . .

One sure way to lift my spirits is . . . . .

I am . . . . . .

Appendix B

ASSERTIVENESS INVENTORY

Step One: Answer each question by using the terms always, often, sometimes, never.

Step Two: Circle the answers that indicate you have a difficulty in assertion. Then, see if you can write a sentence or a series of sentences after these circled answers explaining your assertive problems in your own words. Do this on the back for those with which you have particular difficulty. Number them accordingly. For example, if your answer to Question 7 shows you feel dissatisfied with your social life, you might write "I have no social life because I don't like to make overtures and no one makes them to me."

1. Do you buy things you don't really want because it is difficult to say no to the salesman?
   Always_____ Often_____ Sometimes_____ Never_____
2. Do you hesitate to return items to a store even when there is a good reason to do so?
   Always_____ Often_____ Sometimes_____ Never_____
3. If someone talks aloud during a movie, play, or concert, can you ask him to be quiet?
   Always_____ Often_____ Sometimes_____ Never_____
4. Can you begin a conversation with a stranger?
   Always_____ Often_____ Sometimes_____ Never_____
5. Do you have trouble maintaining conversations in social situations?
   Always_____ Often_____ Sometimes_____ Never_____
6. Do people act as if they find you boring?
   Always_____ Often_____ Sometimes_____ Never_____
7. Are you satisfied with your social life?
   Always_____ Often_____ Sometimes_____ Never_____
8. When a friend makes an unreasonable request, are you able to refuse?
   Always_____ Often_____ Sometimes_____ Never_____
9. Are you able to ask favors or make requests of your friends?
   Always_____ Often_____ Sometimes_____ Never_____
10. Can you criticize a friend?
    Always_____ Often_____ Sometimes_____ Never_____
11. Can you praise a friend?
    Always_____ Often_____ Sometimes_____ Never_____
12. When someone compliments you, do you know what to say?
    Always_____ Often_____ Sometimes_____ Never_____
13. Is there someone with whom you can share your intimate feelings?
    Always_____ Often_____ Sometimes_____ Never_____
14. Would you rather bottle up your feelings than make a scene?
    Always_____ Often_____ Sometimes_____ Never_____
15. Are you satisfied with your work habits?
    Always_____ Often_____ Sometimes_____ Never_____
16. Do people tend to exploit you or push you around?
    Always_____ Often_____ Sometimes_____ Never_____
17. Can you be open and frank in expressing both tender and angry feelings to men?
    Always_____ Often_____ Sometimes_____ Never_____

18. Can you be open and frank in expressing both tender and angry feelings to women?
Always_____ Often_____ Sometimes_____ Never_____
19. Do you find it difficult to make or accept dates?
Always_____ Often_____ Sometimes_____ Never_____
20. Are you spontaneous during sex play and intercourse?
Always_____ Often_____ Sometimes_____ Never_____
21. Are you satisfied with your progress in your career?
Always_____ Often_____ Sometimes_____ Never_____
22. Do you find it difficult to upbraid a subordinate?
Always_____ Often_____ Sometimes_____ Never_____
23. Are you (or would you be) a good model of assertiveness for your own child?
Always_____ Often_____ Sometimes_____ Never_____

Appendix C

UPTIGHT INVENTORY

Step One: Add to the list any additional stimuli which produce disturbed feelings in you.

Step Two: Indicate the extent to which each of the items sets off uptight feelings in you. Use the scale: Not at all A little Much Very much. Put your answer next to the item, and, in giving it, show what you feel at this moment - not how you reacted at some time in the past, or how you think you should feel.

(Check One)	Not at All	A Little	Much	Very Much
1. Loud voices	_____	_____	_____	_____
2. Speaking in public	_____	_____	_____	_____
3. People who seem insane	_____	_____	_____	_____
4. Being teased	_____	_____	_____	_____
5. Failure	_____	_____	_____	_____
6. Strangers	_____	_____	_____	_____
7. Feeling angry	_____	_____	_____	_____
8. People in authority	_____	_____	_____	_____
9. Feeling tender	_____	_____	_____	_____
10. Tough-looking people	_____	_____	_____	_____
11. Being watched while at work	_____	_____	_____	_____
12. Receiving a compliment	_____	_____	_____	_____
13. Being criticized	_____	_____	_____	_____
14. Angry people	_____	_____	_____	_____
15. Being ignored	_____	_____	_____	_____
16. Looking foolish	_____	_____	_____	_____
17. Being disliked	_____	_____	_____	_____
18. Making mistakes	_____	_____	_____	_____
19. A lull in the conversation	_____	_____	_____	_____

Add your own to this list if there are some that I have missed.

(Check One)	Not at All	A Little	Much	Very Much
20.	_____	_____	_____	_____
21.	_____	_____	_____	_____
22.	_____	_____	_____	_____
23.	_____	_____	_____	_____
24.	_____	_____	_____	_____
25.	_____	_____	_____	_____

Appendix D

PHYSICAL INDEPENDENCE INVENTORY

Read each group of statements carefully. Then circle the number beside the statement that best describes you. After you have completed the questionnaire, add up all the numbers circled. Check your total with the totals given at the end of the questionnaire.

1. 0 I'm able to do basic housekeeping tasks (making beds, doing dishes).
   1 I have some trouble with basic housekeeping tasks.
   2 I have a great deal of trouble with basic housekeeping tasks.
   3 My house is a mess.
2. 0 I'm able to do my own cooking.
   1 I have some trouble doing my own cooking.
   2 I have a lot of trouble doing my own cooking.
   3 I don't do any of my own cooking.
3. 0 I take care of my personal hygiene.
   1 I have some trouble taking care of my personal hygiene.
   2 I have a lot of trouble taking care of my personal hygiene.
   3 I don't take care of my personal hygiene.
4. 0 I am able to keep track of my personal belongings.
   1 I have some trouble keeping track of my personal belongings.
   2 I have a lot of trouble keeping track of my personal belongings.
   3 I have to ask others where my things are.
5. 0 I can look up and dial numbers regularly.
   1 I dial a few well-known numbers, but seldom use the phone book.
   2 I answer the phone but rarely dial.
   3 I never use the telephone.
6. 0 I can take care of all my own shopping.
   1 I can shop for small items but want assistance with large items.
   2 I want to be accompanied on shopping trips.
   3 I'm unable to shop for myself.
7. 0 I can plan and make meals for myself.
   1 I can make adequate meals if given the food.
   2 I can heat prepared meals but don't eat adequately.
   3 I'm unable to make my meals.
8. 0 I can maintain my house alone.
   1 I need help for everything except tasks like dishwashing and bedmaking.
   2 I need help with all housekeeping tasks.
   3 I can't do any housekeeping tasks.
9. 0 I can do all of my own laundry.
   1 I can launder the small items but not large items like sheets and towels.
   2 I can launder a few small items.
   3 All of my laundry is done by someone else.
10. 0 I can travel by myself in my car or by public transportation.
   1 I use public transportation when assisted or accompanied by another.
   2 I travel by car with assistance of another.
   3 I almost never travel.

11. 0 I take care of my own medication - the dosages and timing.
    1 I take my own medication but occasionally forget.
    2 I can take my own medication if someone reminds me.
    3 I don't take care of my own medication.
12. 0 I'm able to do most household repairs.
    1 With some help I can do moderately difficult household repairs.
    2 I do simple repairs such as hanging a picture or changing a light bulb.
    3 I'm unable to do simple household chores or repairs.
13. 0 I can drive alone.
    1 I can drive alone but sometimes get lost.
    2 I drive when someone else is with me.
    3 I can't drive.
14. 0 I always take care to look clean, neat and well dressed.
    1 I take care to bathe and be neat, and sometimes dress well.
    2 I bathe and dress myself, but don't care how I look.
    3 I don't bathe and dress myself and I don't care how I look.
15. 0 I enjoy preparing and eating regular meals and my favorite foods.
    1 I regularly prepare simple meals.
    2 I occasionally prepare simple meals, but don't enjoy eating.
    3 I don't eat regular meals and eat only when I become very hungry.
16. 0 I keep my daily agreements (what I say to myself and others that I'll do).
    1 I keep my daily agreements, with some help.
    2 I keep my daily agreements about half the time.
    3 I cannot keep my daily agreements.
17. 0 I do not feel ashamed of how I keep my daily agreements.
    1 I occasionally feel a little ashamed of how I keep my daily agreements.
    2 About half the time I feel ashamed of how I keep my daily agreements.
    3 I feel ashamed of how I keep my daily agreements.
18. 0 I get along with salespeople and tradespeople.
    1 I usually get along well with salespeople and tradespeople, but have minor arguments.
    2 I often argue with salespeople and tradespeople.
    3 I have many arguments with salespeople and tradespeople.
19. 0 I'm in good physical condition.
    1 I'm in fair physical condition.
    2 I'm in poor physical condition.
    3 I'm in very poor physical condition.
20. 0 I exercise regularly.
    1 I exercise occasionally.
    2 I rarely exercise.
    3 I never exercise.
21. 0 I don't smoke.
    1 I ocasionally smoke.
    2 I'm dependent on a pack of cigarettes a day.
    3 I'm dependent on more than a pack of cigarettes a day.

22. 0 I have no trouble with drinking alcohol.
    1 I occasionally drink too much alcohol.
    2 I often drink too much alcohol.
    3 I'm completely dependent on alcohol.
23. 0 I'm not dependent on any drugs or medication.
    1 I habitually take some drugs or medication.
    2 I'm partly dependent on some drugs or medication.
    3 I'm completely dependent on some drugs or medication.
24. 0 I wake myself up in the morning when I have to be some place on time.
    1 I usually wake myself up in the morning when I have to be some place on time.
    2 I rarely wake myself up in the morning when I have to be some place on time.
    3 Someone always wakes me up in the morning when I have to be some place on time.
25. 0 I can use a map to find my way around.
    1 I can usually find my way around.
    2 I sometimes have to ask for help to find my way around.
    3 I have to count on someone else to help me find my way to places I've never been before.
26. 0 I always make my own reservations (dinner, flights, and so forth).
    1 I usually make my own reservations.
    2 I rarely make my own reservations.
    3 I never make my own reservations.
27. 0 I always return unwanted merchandise myself.
    1 I usually return unwanted merchandise myself.
    2 I sometimes return unwanted merchandise myself.
    3 I rarely return unwanted merchandise myself.
    4 I have someone else return unwanted merchandise - or I keep it.

RESULTS:
Score of 0-6 = high level of physical independence.
Score of 7-17 = moderate level of physical independence.
Score of 18-25 = low level of physical independence.
Score of 25 or above = severe problem with physical independence.

Appendix E

EMOTIONAL INDEPENDENCE INVENTORY

Read each group of statements carefully. Then circle the number beside the statement that best describes you. After you have completed the questionnaire, add up all the numbers circled. Check your total with the totals given at the end of the questionnaire.

1. 0 I don't feel like I'm waiting for something or someone to make me happy.
   1 I sometimes feel like I'm waiting for something or someone to make me happy.
   2 I often feel like I'm waiting for something or someone to make me happy.
   3 I am waiting for something or someone to make me happy.
2. 0 I feel happy most of the time.
   1 I sometimes feel unhappy.
   2 I feel sad all of the time.
   3 I'm so unhappy that I can't stand it.
3. 0 I don't feel afraid.
   1 I feel afraid.
   2 I feel afraid all the time and can't snap out of it.
   3 I am so afraid that I can't stand it.
4. 0 I don't feel angry.
   1 I feel angry.
   2 I feel angry all the time and can't snap out of it.
   3 I am so angry that I can't stand it.
5. 0 I don't feel guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all the time.
6. 0 I feel equal to others.
   1 I am critical of myself.
   2 I blame myself all the time.
   3 I blame myself for everything bad that happens.
7. 0 I sleep soundly most of the time.
   1 I usually sleep through the night but often wake up tired.
   2 I sleep fitfully and wake up in the night.
   3 I have trouble falling asleep and staying asleep and often have bad dreams.
8. 0 I almost never feel bored.
   1 I usually don't feel bored.
   2 About half the time I feel bored.
   3 Most of the time I feel bored.
9. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.
10. 0 I get as much pleasure out of life as I used to.
    1 I don't enjoy life the way I used to.
    2 I don't get real satisfaction out of life anymore.
    3 I am dissatisfied with everything.

11. 0 I can work about as well as before.
    1 I need extra effort to get started doing anything.
    2 I have to push myself very hard to do anything.
    3 I can't do any work at all.
12. 0 I'm tolerant of others.
    1 I'm somewhat critical of others.
    2 I'm often critical of others.
    3 I'm highly critical of others.
13. 0 I rarely blame others for my problems.
    1 I sometimes blame others for my problems.
    2 I often blame others for my problems.
    3 I'm constantly blaming others.
14. 0 I'm rarely fearful when out by myself.
    1 I'm sometimes fearful when out by myself.
    2 I'm often fearful when out by myself.
    3 I'm nearly always fearful when out by myself.
15. 0 I'm rarely shy with others.
    1 I'm sometimes shy with others.
    2 I'm often shy with others.
    3 I'm usually shy with others.
16. 0 I'm rarely lonely.
    1 I'm sometimes lonely.
    2 I'm often lonely.
    3 I'm usually lonely.
17. 0 My feelings aren't easily hurt.
    1 My feelings are sometimes easily hurt.
    2 My feelings are often easily hurt.
    3 My feelings are very easily hurt.
18. 0 I rarely worry about hurting others' feelings.
    1 I sometimes worry about hurting others' feelings.
    2 I often worry about hurting others' feelings.
    3 I always worry about hurting others' feelings.
19. 0 I'm rarely suspicious of others.
    1 I'm sometimes suspicious of others.
    2 I'm often suspicious of others.
    3 I'm highly suspicious of others.
20. 0 I'm rarely self-conscious.
    1 I'm sometimes self-conscious.
    2 I'm often self-conscious.
    3 I'm nearly always self-conscious.
21. 0 I rarely have urges to beat or harm someone.
    1 I sometimes have urges to beat or harm someone.
    2 I often have urges to beat or harm someone.
    3 I nearly always have urges to beat or harm someone.
22. 0 I rarely have to check and double-check what I do.
    1 I sometimes have to check and double-check what I do.
    2 I often have to check and double-check what I do.
    3 I always have to check and double-check what I do.
23. 0 I rarely feel uncomfortable eating or drinking in public.
    1 I sometimes feel uncomfortable eating or drinking in public.
    2 I often feel uncomfortable eating or drinking in public.
    3 I always feel uncomfortable eating or drinking in public.

24. 0 I rarely resent others.
    1 I sometimes resent others.
    2 I often resent others.
    3 I always resent others.
25. 0 I nearly always trust those close to me.
    1 I sometimes don't trust those close to me.
    2 I often don't trust those close to me.
    3 I never trust those close to me.
26. 0 I never feel inferior.
    1 I sometimes feel inferior.
    2 I often feel inferior.
    3 I always feel inferior.
27. 0 I never feel jealous.
    1 I sometimes feel jealous.
    2 I often feel jealous.
    3 I always feel jealous.

RESULTS:
Score of 0-6 = high level of emotional independence.
Score of 7-17 = moderate level of emotional independence.
Score of 18-25 = low level of emotional independence.
Score of 25 or above = severe problem with emotional independence.

Appendix F

SOCIAL INDEPENDENCE INVENTORY

Read each group of statements carefully. Then circle the number beside the statement that best describes you. After you have completed the questionnaire, add up all the numbers circled. Check your total with the totals given at the end of the questionnaire.

1. 0 I'm direct when I talk to others.
   1 I'm usually direct when I talk to others.
   2 It's difficult for me to be direct when I talk to others.
   3 It's impossible for me to be direct when I talk to others.
2. 0 I don't overcompliment others.
   1 I occasionally get carried away and overcompliment others.
   2 I often overcompliment others.
   3 I always overcompliment others.
3. 0 I rarely feel shame around others.
   1 I occasionally feel shame around others.
   2 I often feel shame around others.
   3 I feel shame around others.
4. 0 When I want to do something for enjoyment, I usually find someone to join me.
   1 I often end up doing things alone even though I'd like to have someone join me.
   2 There's no one right now I can go out and enjoy things with.
   3 There hasn't been anyone I could go out and enjoy things with for several years.
5. 0 There is someone I am intimate with now on a regular basis.
   1 I am not intimate with anyone now on a regular basis.
   2 I am often disturbed that I am not intimate with someone on a regular basis.
   3 I have never been intimate with anyone on a regular basis for several months.
6. 0 I have seen or spoken to friends three or four times in the last two weeks.
   1 I have seen or spoken to friends two or three times in the last two weeks.
   2 I have seen or spoken to one friend in the last two weeks.
   3 I have not seen or spoken to a friend in the last two weeks.
7. 0 I can always talk about my innermost feelings to friends if I choose to.
   1 About half the time I feel able to talk about my innermost feelings to friends.
   2 I am usually not able to talk about my feelings
   3 I am never able to talk about my feelings
8. 0 I haven't had any open arguments with my friends in the last two weeks.
   1 I usually get along well with my friends but have minor arguments.
   2 I have many arguments with my friends.
   3 I am constantly in arguments with my friends.

9. 0 My feelings were not hurt or offended by a friend in the past two weeks.
   1 My feelings were hurt or offended, but I got over it in a few hours.
   2 My feelings were hurt or offended, but I got over it in a few days.
   3 My feelings were hurt or offended and it will take me months to recover.
10. 0 I have not felt shy or uncomfortable with people in the last two weeks.
   1 I sometimes feel uncomfortable but can relax after a while.
   2 About half the time I feel uncomfortable with people.
   3 I always feel uncomfortable with people.
11. 0 I have not felt lonely and have not wished for more friends during the last two weeks.
   1 I have felt lonely a few times.
   2 About half the time I felt lonely.
   3 I always feel lonely and wish for more friends.
12. 0 I'm married or in a relationship, but I enjoy going out alone.
   1 I go out alone but prefer to go with my partner.
   2 I rarely go anywhere without my partner.
   3 I do everything with my partner.
13. 0 I always get along well with my relatives.
   1 I usually get along well with my relatives but have had some minor arguments.
   2 I have many arguments with my relatives.
   3 I am constantly in arguments with my relatives.
14. 0 I contact my relatives regularly.
   1 I wait for my relatives to contact me.
   2 I avoid my relatives but they contact me.
   3 I have no contact with any relatives.
15. 0 I have not depended on my relatives for help, advice, money or friendship during the last two weeks.
   1 I depended on my relatives three or four times during the last two weeks.
   2 I depended on my relatives about half the time during the last two weeks.
   3 I depended completely on my relatives during the last two weeks.
16. 0 I don't feel that I've let my relatives down.
   1 I usually don't feel that I've let my relatives down.
   2 Most of the time I feel I've let my relatives down.
   3 I always feel I've let my relatives down.
17. 0 I don't feel that my relatives have let me down or been unfair to me.
   1 I feel that my relatives usually don't let me down.
   2 I feel that my relatives let me down most of the time.
   3 I am very bitter that my relatives are unfair to me and let me down.

18. 0 I can always talk freely about my problems and feelings with my partner.
    1 I usually talk freely about my feelings with my partner.
    2 I usually am not able to talk freely with my partner.
    3 I am not able to talk freely with my partner.
19. 0 I am almost never bossed around by my partner.
    1 I am bossed around by my partner occasionally.
    2 I am bossed around by my partner most of the time.
    3 I am always bossed around by my partner.
20. 0 I am not dependent on my partner.
    1 I am not occasionally dependent on my partner.
    2 I am often dependent on my partner.
    3 I am dependent on my partner for everything.
21. 0 I always feel affection for my partner.
    1 I usually feel affection for my partner.
    2 I seldom feel affection for my partner.
    3 I never feel affection for my partner.
22. 0 I don't get upset when my partner acts like a different person.
    1 I sometimes get upset when my partner acts like a different person.
    2 I get pretty upset when my partner acts like a different person.
    3 It is upsetting when my partner acts like a different person.
23. 0 I feel pleased about my interactions with my partner.
    1 I sometimes feel unhappy about my interactions with my partner.
    2 I often feel unhappy about my interactions with my partner.
    3 I am unhappy about my interactions with my partner.
24. 0 My partner is not dependent on me.
    1 I feel my partner may be a little dependent on me.
    2 I feel my partner is too dependent on me.
    3 My partner is too dependent on me.
25. 0 I have as much privacy as I'd like.
    1 I could use more privacy from my partner.
    2 I want more privacy from my partner.
    3 I don't have enough privacy from my partner.
26. 0 I don't feel uncomfortable when I go out in public.
    1 I sometimes feel uncomfortable when I go out in public.
    2 I often feel uncomfortable when I go out in public.
    3 I feel uncomfortable when I go out in public.
27. 0 I'm not particularly afraid of strangers.
    1 I'm sometimes afraid of strangers.
    2 I'm often afraid of strangers.
    3 I'm terrified of strangers.

RESULTS:
Score of 0-6 = high level of social independence.
Score of 7-17 = moderate level of social independence.
Score of 18-25 = low level of social independence.
Score of 25 or above = severe problem with social independence.

Appendix G

EVALUATION OF MEDICAL ASSISTANT PILOT PROGRAM

Read the following questions carefully and please comment thoughtfully. Your responses to this evaluation will remain anonymous.

1. What is your overall rating of the pilot program?

   (Check One) Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___

   Comments: _____

   _____

2. How would you rate the instructor?

   Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___

   Comments: _____

   _____

3. How would you rate the appropriateness of the program for future students enrolled in the Medical Assistant Program?

   Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___

   Comments: _____

   _____

4. How would you rate the pilot program relative to your own personal growth and development?

   Excellent ___ Very Good ___ Good ___ Fair ___ Poor ___

   Comments: _____

   _____

5. What did you enjoy most about the pilot program? _____

   _____

   _____

6. What did you enjoy least about the pilot program? _____

   _____

   _____

7. If the program were to be offered again in the future, what part would you eliminate? _____

   _____

   _____

8. Are there any additional areas you would include in a future program which were not provided in the present course? _____

   _____

   _____